Computerized Patient Record System (CPRS)

User Guide

GUI version

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Department of Veterans Affairs

Technical Service

Computerized Patient Record System Product Line

Revision History

Date	Page	Change
11/2000	109-128	Added appendix for Personal Preferences
8/2001	Various	GUI 16 changes
9/2001	61-70, 82-92	Additions and changes for Pharmacy Ordering Enhancement (POE)

Table of Contents

Introduction

What is CPRS?

The Computerized Patient Record System (CPRS) is a Veterans Health Information Systems and Technology Architecture (VISTA) computer application. CPRS enables you to enter, review, and continuously update all the information connected with any patient. With CPRS, you can order lab tests, medications, diets, radiology tests and procedures, record a patient's allergies or adverse reactions to medications, request and track consults, enter progress notes, diagnoses, and treatments for each encounter, and enter discharge summaries. In addition, CPRS supports clinical decision-making and enables you to review and analyze patient data.

Using CPRS Documentation

Related Manuals

Computerized Patient Record System Installation Guide

Computerized Patient Record System Setup Guide

Computerized Patient Record System Technical Manual

Computerized Patient Record System Online Help

Clinical Reminders Manager Manual

Clinical Reminders Clinician Guide

Text Integration Utility (TIU) Clinical Coordinator and User Manual

Consult/Request Tracking User Manual

VistA Intranet

CPRS documentation is also available on the VistA intranet. The intranet version is constantly updated and may contain more current information than this print version. CPRS documentation is available on the VistA intranet at http://vista.med.va.gov/cprs/.

Online Help

Instructions, procedures, and other information are available from the CPRS online help file. You may access the help file by clicking on **Help | Contents** from the menu bar or by pressing the F1 key while you have any CPRS dialog open. Much of the information in this User Manual is also in the CPRS online help.

CPRS Graphical User Interface (GUI)

CPRS was designed to run in both the Microsoft Windows operating environment and on text-based terminals. The terminal or text-based version of CPRS (also known as the List Manager version) is not described in this manual. This manual describes the Windows version of CPRS.

The Organization of this Manual

This manual is organized in the way most people will use the CPRS GUI. It begins with how to log on to the system and then how to select a patient. The manual continues with an explanation of the features that are available from each CPRS tab.

We hope this organization will help you understand the basic layout of the CPRS GUI and provide you with information about the specific tasks you will perform.

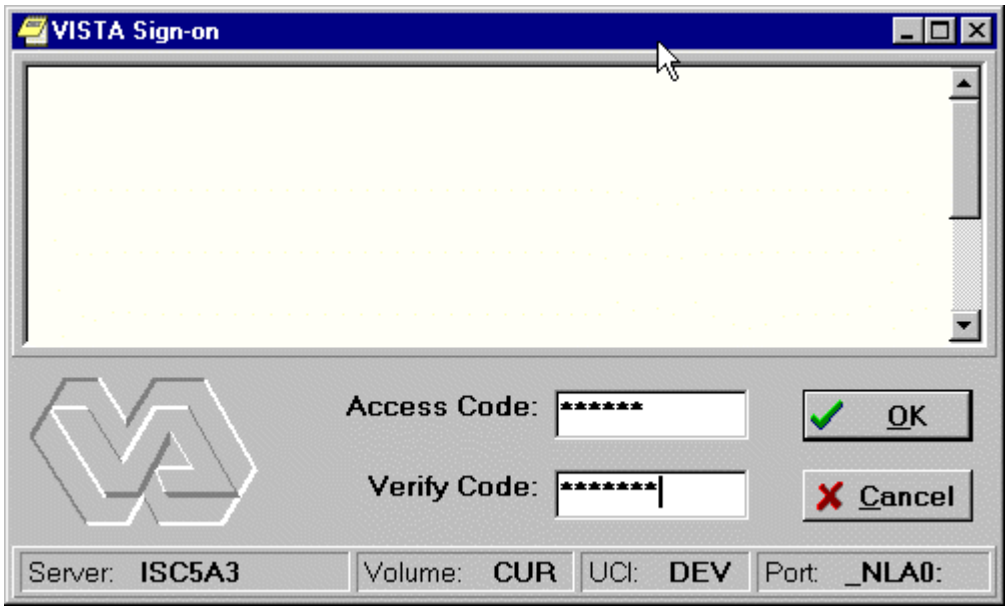
Signing on to CPRS

Once CPRS has been installed on your workstation and you have been issued an access code and a verify code, you can sign onto CPRS. To start CPRS, double-click on the CPRS icon on your desktop. The VISTA logo window opens for a few moments and is followed by the VISTA Sign-on dialog.

If the Connect To dialog appears, click on the down-arrow, select the appropriate account (if more than one exists), and click **OK**.

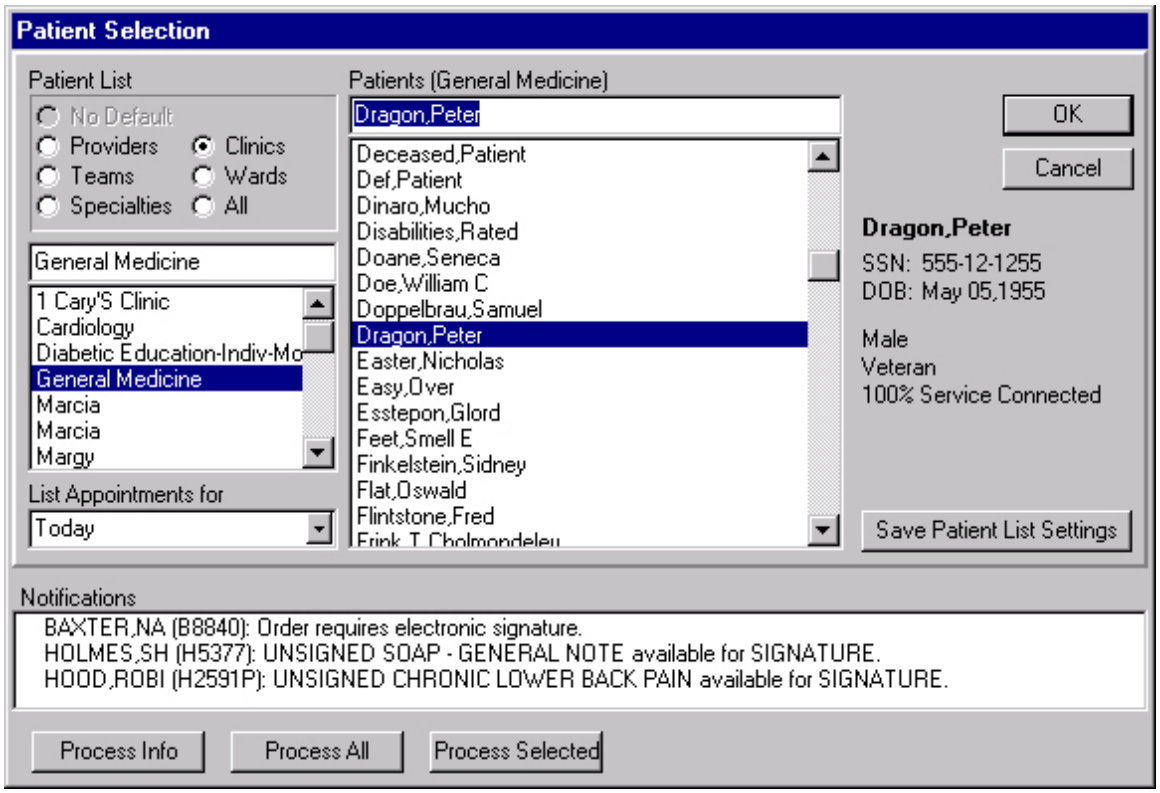
Type your access code into the Access Code field and press the **Tab** key. Then, type your verify code into the Verify Code field and press the **Enter** key or click on **OK**.

Shortcut: You can also type the access code, followed by a semicolon, followed by the verify code. Once you have done this press the **Enter** key or click **OK**.



Selecting a Patient

After you log in to CPRS, the Patient Selection screen, shown below, is the first thing to appear. You should now select a patient record to view.



To select a patient record, follow these steps:

1. Do one of the following:
   a. Type the patient's full social security number with or without dashes (123-44-4444 or 123444444) or type the full social security number with “P” as the last character (123-44-4444p, or 123444444p).
   b. Type part or all of the patient’s name (e.g. “smit” or “smith, joe”).
   c. Type the first letter of the patient’s last name and the last four digits of the patient’s Social Security number (s4444).

   CPRS will try to match what you entered to a patient and highlight that patient. The patient's name and other information will appear below the Cancel button.
2. Verify that the correct patient is highlighted. If the correct patient is highlighted, click **OK**. If the correct patient is not highlighted, scroll through to find the correct patient, highlight the name, and then click **OK**.

   When you click OK, CPRS opens to the Cover Sheet.

You can also use the radio buttons under the Patient List heading (located on the left-side of the window) to group the patient list according to provider, team, specialty, clinic, or ward. When you select a specific list for a provider, team, specialty, clinic, or ward, CPRS will display the associated patients in the Patients list box, followed by a line, and then the

comprehensive patient list. You can then scroll to find the name. Your Clinical Coordinator will usually create the lists for the teams, wards, and so on.

Patient Selection Messages

When you select a patient record to open, you may receive one or more of the following messages:

- **Means Test Required –** This message tells you that the patient's ability to pay for medical services must be evaluated.
- **Legacy Data Available –** This message would be found only at a consolidated facility. It informs you that the selected patient has data from the system you used before your site was consolidated that is not being displayed and that you may want to access.
- **Sensitive Patient Record –** This indicates that the record is sensitive and may only be viewed by authorized users.
- **Deceased Patient –** This message tells you that the selected patient is deceased.
- **Patient with Similar Name or Social Security Number –** This message appears if you enter only part of a patient's name or the last four digits of a social security number. If CPRS finds more than one match for what you have entered, this message appears and CPRS presents the possible matches so that you can select the right one.

Patient Lists

You or your clinical coordinator can create patient or team lists that simplify tasks such as reviewing patient charts, ordering, and signing orders and notes. These lists can be based on wards, clinics, teams, or other groups. Patient lists are managed through the List Manager interface (the character-based version of CPRS).

With patient lists you can:

- Quickly locate your patients without going through all the patients in the list.
- Create lists for teams of clinicians who can sign or cosign for each other.
- Tie notifications to teams, ensuring that all team members receive necessary information about a patient.

Setting a Default Patient List

To make it easier for you to locate your patients, CPRS enables you to set a default patient list. This is the list that will appear when you launch CPRS. For example, if you work in a specific ward, you can set the default patient list to be the list for that ward.

To set the default patient list, use these steps:

1. If you are just opening CPRS, skip to step 2. Otherwise, select **File | Select New Patient...**.

2. In the Patient Selection screen, select the category in which you want to search for a patient's record by clicking the option button in front of the category (Default, Providers, Teams, Specialties, Clinics, Wards, or All).
3. In the list box below the option button, click the item that narrows the search further (such as a specific ward).

   If you select something other than All, CPRS sorts the patient list and divides the list into two parts: The names above the line are the names for the category and item you selected; the names below the line make up a comprehensive patient list.
4. To save the patient list you have chosen, click **Save Patient List Settings**.

Notifications

Notifications are messages that provide information or prompt you to act on a clinical event. Clinical events, such as a critical lab value or a change in orders trigger a notification to be sent to all recipients identified by the triggering package (such as Lab, CPRS, or Radiology). The notifications are located on the bottom of the Patient Selection screen.

CPRS places an "I" before "information-only" notifications. Once you view (process) information-only notifications, CPRS deletes them. When you process notifications that require an action, such as signing an order, CPRS brings up the chart tab and the specific item (such as a note requiring a signature) that requires action.

> **Note**: When CPRS is installed, all notifications are disabled. IRM staff and clinical coordinators set site parameters through the Notifications Management Menus in the List Manager version of CPRS that enable specific notifications. Notifications are initially sent to all users. Users can then disable unwanted notifications through List Manager's Personal Preferences.

Notifications are retained for a predetermined amount of time (up to 30 days), after which they may be sent to another destination, such as your MailMan surrogate or your supervisor. Confer with your clinical coordinator to establish and set up these options. You can also confer with your clinical coordinator to select what types of notifications you will receive. Some notifications are mandatory, however, and cannot be disabled.

Clinical Notifications are displayed on the bottom of the Patient Selection screen when you log in to CPRS. Only notifications for *your* patients are shown.

Processing Notifications

CPRS provides you with flexibility in choosing which notifications you will process. You have three choices: Process Info, Process All, and Process Selected.

To process notifications, use these steps:

1. Bring up the Patient Selection screen, either by launching CPRS or if you are already running CPRS, selecting **File | Select New Patient**.
2. Decide which notifications to process.
   - To process all information notifications (items preceded by an I.), click **Process Info**.
   - To process all notifications, click **Process All**.

- To process specific notifications, highlight one or more notifications, and then click **Process Selected**. You can also process a notification by double-clicking on it.

  Note: To select a number of notifications in a row, click the first item, hold down the Shift key, and click the last item. All items in the range will be selected. To select multiple items that are not in a row, click one, hold down the Control key, and click the other specific notifications.

3. Process the notification by completing the necessary task, such as signing an overdue order or viewing information notifications.
4. Click the **Next** button on the status bar.
5. Process the remaining notifications using steps 3 and 4.
6. When finished, you may select a new patient (**File | Select New Patient…**) or exit CPRS (**File | Exit**).

Refreshing a Patient Record

You can refresh a patient's information so that recent changes will be reflected. To refresh a patient's records, click File | Refresh Patient Information. This option will refresh the information of the currently selected patients in the same manner that changing patients looks for the latest information. Refreshing a patient's information will result in notes in progress being saved, and the review/sign changes screen will appear if changes are pending.

Features Available from Any Tab

In the CPRS GUI, the tabs are intended to mimic the paper chart. Chart tabs divide functionality. Even the menu items on the View and Action menus change depending on which tab is selected.

However some features are available regardless of which tab is active:

- Patient Inquiry
- Current Activities (Encounter Provider and Location)
- Primary Care
- Remote Data Views
- Reminders
- Postings (CWAD)

These buttons are located on the top of the chart below the menu bar as shown in the graphic below.

All of these items have two purposes. They provide you with immediate feedback about the patient or the patient's care, and they provide additional information when clicked.

Each of these items will be discussed briefly to help you understand what they do and how they can be useful to you.

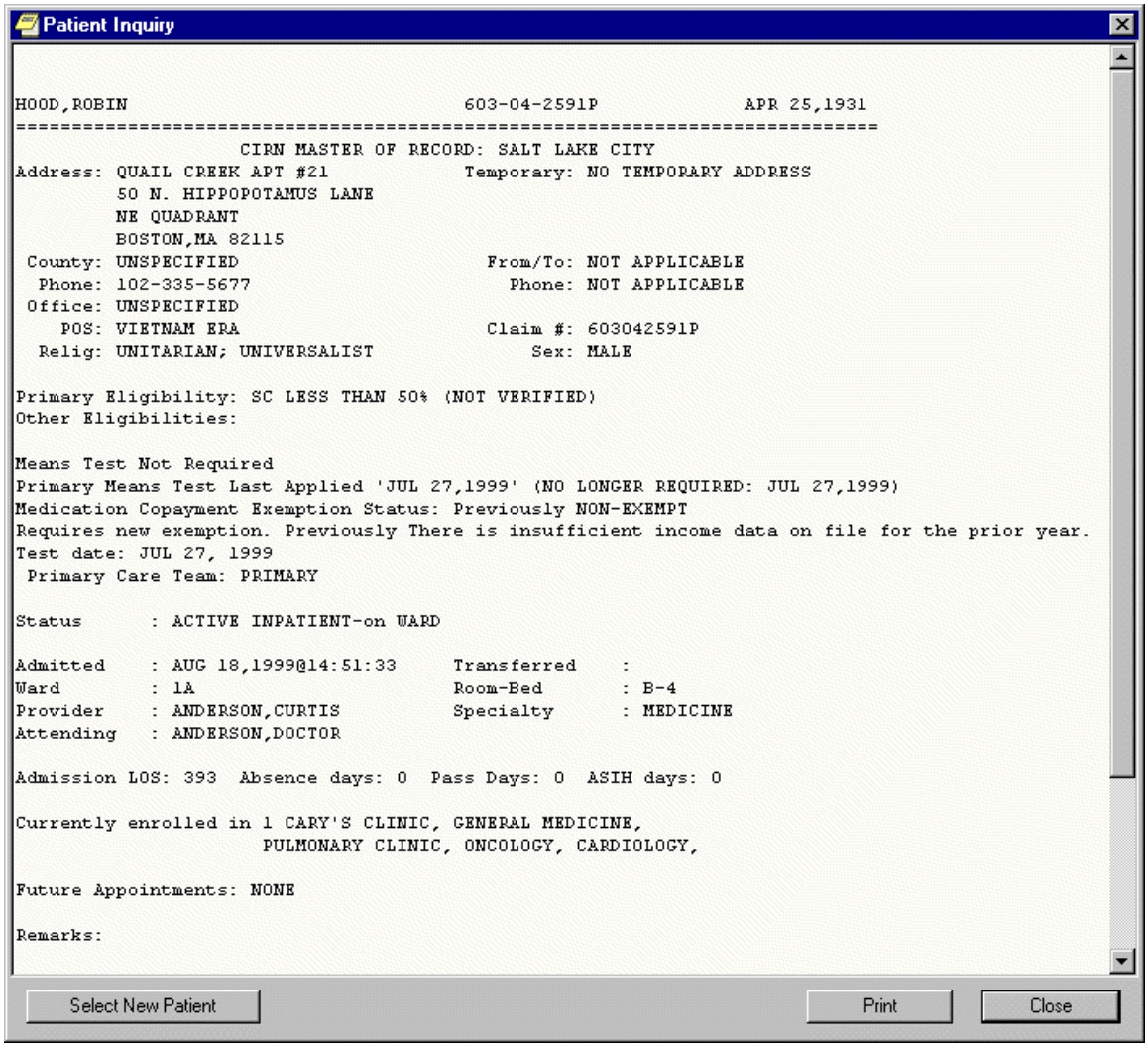
Patient Inquiry

The Patient Inquiry button is on the left of the chart directly below the menu bar. The following graphic shows the Patient Inquiry button highlighted.

It displays the following:

- Patient name
- Social Security number (or identification number if assigned by the site)
- Date of birth
- Age

If you click on the button, you get more detailed information including mailing address, telephone numbers, admission information and so on.



While in the detailed display, you can select a new patient, print the detailed display, or close the detailed display.

Encounter Identification

CPRS has two kinds of encounter information: visit information and encounter form data. Encounter form data is explained later in this manual.

For each visit (or telephone call) with a patient, you need to enter the provider, location, date, and time. CPRS requires this information before you can place orders, write notes, add to the problem list, and so on.

The parameter, ORWPCE ANYTIME ENCOUNTERS, can be set to allow encounters to be entered on the Notes tab when no note is being entered. This will allow encounter entry (at the time of the visit) for dictated notes. This parameter can be set at the User, Service, Division, and System levels. Note that this will edit the encounter associated with the current location and time, which is not necessarily the encounter associated with the currently displayed note.

To receive workload credit, you must enter the encounter form data, including the following information, for each encounter:

- Service connection
- Provider name
- Location
- Date
- Diagnosis
- Procedure

Visit / Encounter Information

CPRS shows the encounter provider and location for the visit on the Visit Encounter button. You can access this feature from any chart tab. This procedure can be used to schedule new encounters, access existing encounters, and create unscheduled encounters.

Entering Encounter Provider and Location

If a provider or location has not been assigned, CPRS will prompt you for this information when you try to enter progress notes, create orders, and perform other tasks to track where the patient was seen and by whom. You enter other encounter information such as diagnoses, procedures, and patient education when creating a progress note. This information is discussed later in this manual.

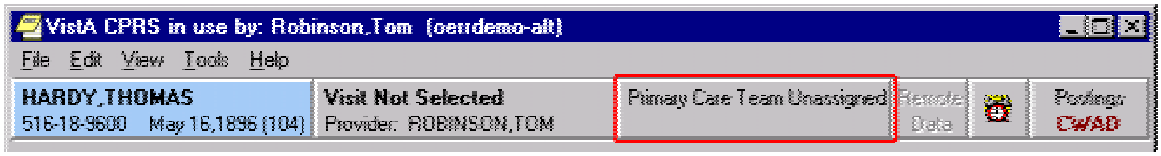
To enter or change the Encounter provider, follow the steps below:

1. If you are already in the Provider / Encounter dialog skip to step 2. Otherwise, from any chart tab, click the **Provider / Encounter** box located in the top center portion of the dialog.
2. Locate and click the provider for this encounter in the list box.
3. Click the tab of the correct encounter category for this visit:
   - Clinic Appointments
   - Hospital Admissions
   - New Visit
4. Select a location for the visit from the choices in the list box.
5. If you selected a Clinic Appointment or Hospital Admission, skip to step 7. If you are creating a New Visit, enter the date and time of the visit (the default is NOW).
6. Click a visit category from the available options (such as, Historical) and click **OK**.
7. When you have the correct provider and location, click **OK**.

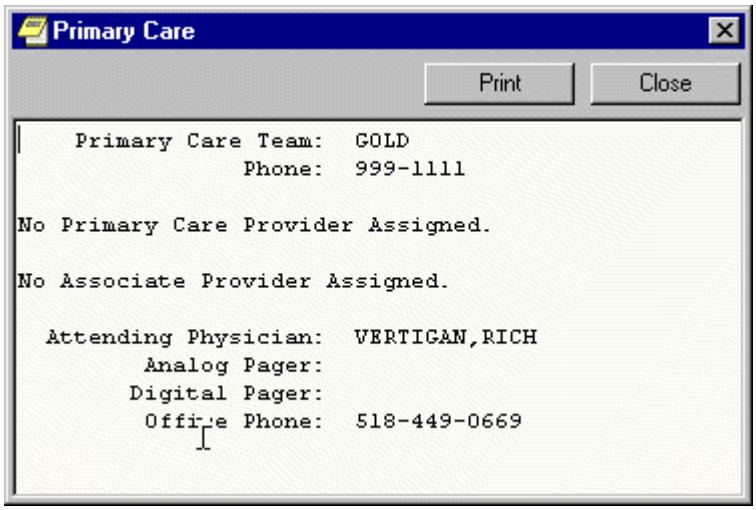
For more information and instructions on entering more encounter form data, refer to the Notes section of this manual.

Primary Care Information

To the immediate right of the Visit Encounter button is the Primary Care button, which allows the user to make an inquiry about the primary care team for a patient. If assigned, the team and attending physician assigned to this patient are visible on the button.



For a detailed display, click the button.



Detailed information might include:

- Primary Care team assigned
- Primary Care Provider assigned
- Associate Provider assigned
- The attending physician's name and contact information

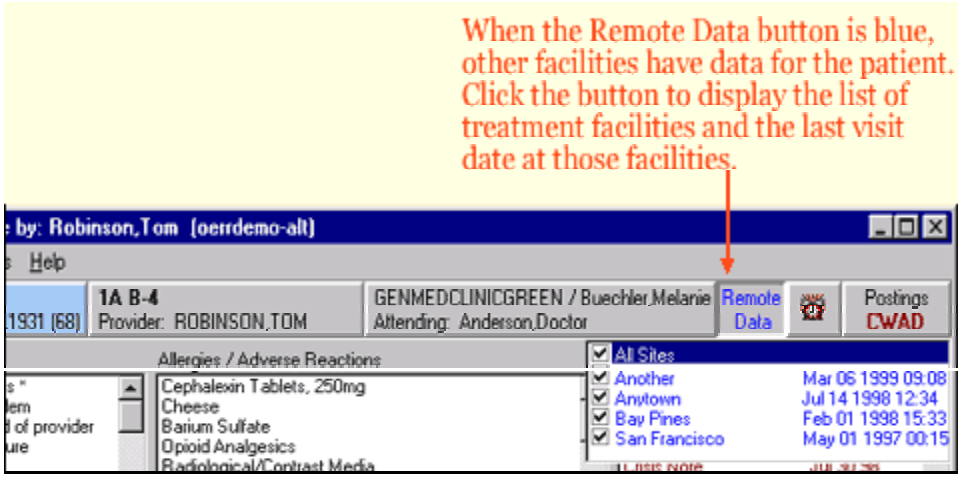
Click on Print to create a hard copy of the data. The patient's name and other vital identification information will appear at the top of the report although they do not appear on the dialog. When finished with the detailed display, click Close.

Remote Data

You can view remote patient data with CPRS if Master Patient Index/Patient Demographics (MPI/PD) and several other patches have been installed at your site. If these patches have been installed and the proper parameters have been set, you can access remote data generated at other VA and Department of Defense (DOD) facilities.

How Do I Know a Patient Has Remote Medical Data?

As part of opening a patient record, CPRS checks in the Treating Facility file to see if the selected patient has been seen in other facilities. If the patient has remote data, the words on the Remote Data button turn blue as shown in the image below. If there is no remote data for the selected patient, the letters are gray.



What Does the List of Sites Represent?

If you click on the Remote Data button, a drop-down list appears with the name(s) of sites where the patient has been seen. This list is based on either:

- Sites that have been specifically designated for your facility to access. These sites are assigned in a parameter that your Clinical Applications Coordinator (CAC) can set up.
- All sites where the patient has been seen.

How Will the Remote Data Be Viewed?

Viewing remote data is a two-step process. First, you select which remote site you want to see data from, and then you select the specific information you want to view, such as lab tests or health summary components.

On the Labs tab and the Reports tab, each site you select will have a separate tab for its data. Using the above graphic as an example, you would see five tabs on the Reports tab: Local, Another, Anytown, Bay Pines, and San Francisco.

You would then go to the Labs or Reports tab, select the reports or lab you want to view and a date range (if necessary). After this, CPRS will attempt to retrieve those reports. You would then click on each tab to see the report from that site. While CPRS is attempting to retrieve the data, the message “Transmission in Progress: “ is displayed until the data is retrieved.

What Kind of Data Can I View?

Currently with CPRS, you can view some lab and health summary components. There are limitations to what you can view.

- You can view any lab result that does not require input other than a date range.
- You can view health summary components that have the same name on both the local and the remote site. You can therefore exchange national Health Summaries, but locally defined components may not be available unless the other site also has a component with the same name.

Viewing Remote Data

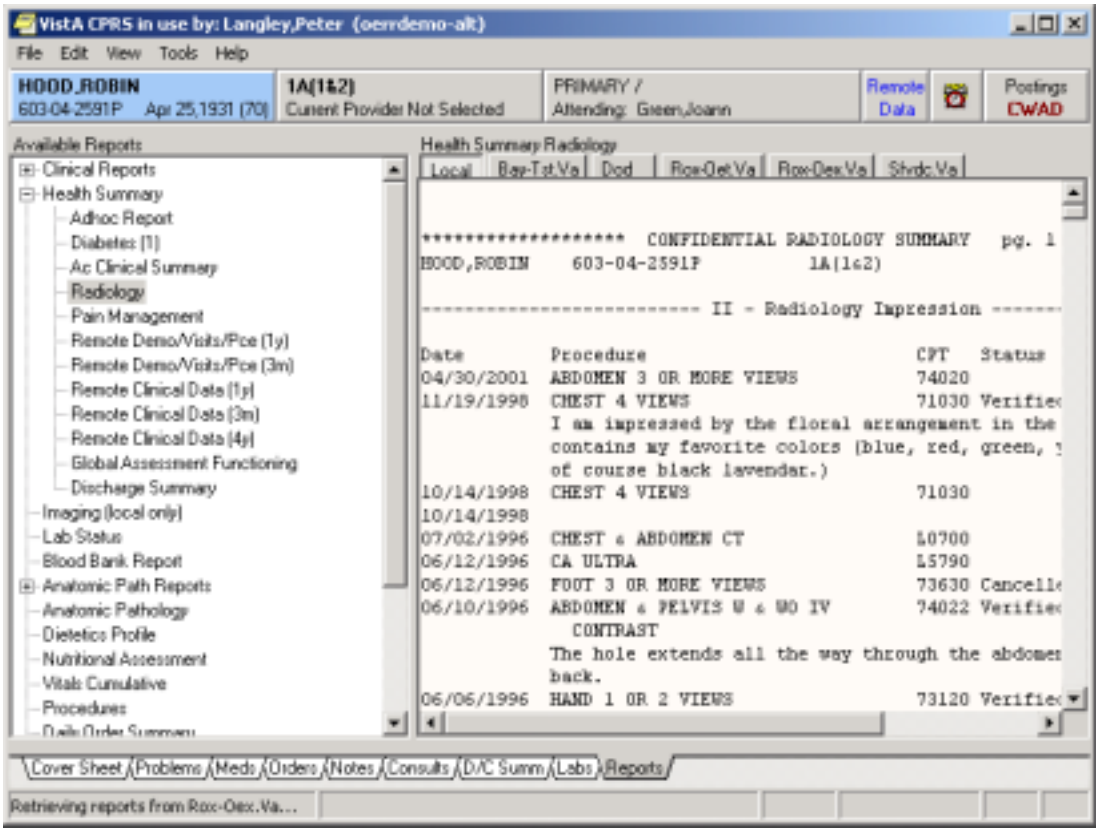
To view a patient’s remote data, use these steps:

1. After opening the patient's record, see if the text on the Remote Data button is blue. If the text is blue, the patient has remote data.
2. Click the tab you want remote data from (e.g. Labs or Reports).
3. Click the **Remote Data** button to display a list of sites that have remote data for the selected patient.
4. Select the sites you want to view remote data from by clicking the check box in front of the site name.
5. Select the report or lab you would like to view from the Available Reports or Lab Results section on the left side of the screen (click the “+” sign in order to expand a report heading).

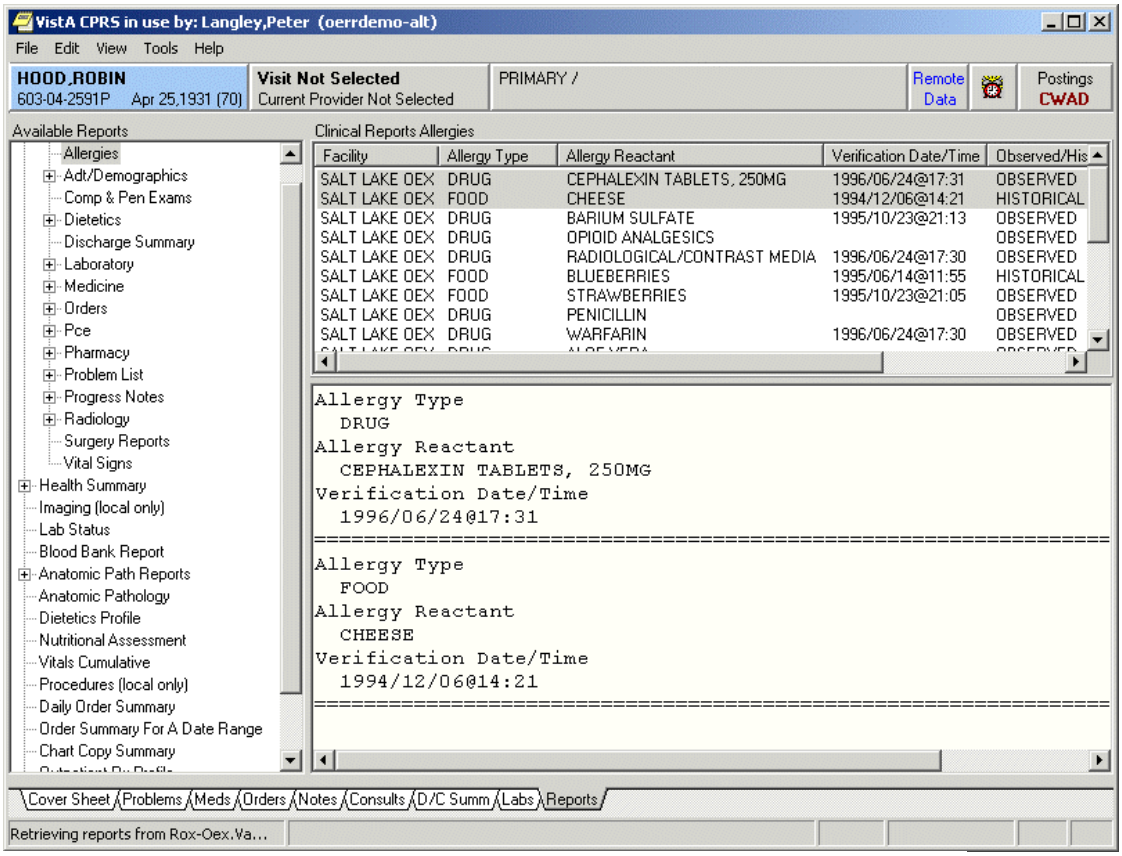
   It may take a few minutes to retrieve the data. While CPRS retrieves the data, the message "Transmission in Progress" is displayed.

6. Depending on how the report or lab is configured, CPRS will return the remote data in one of two ways.

   - **Text Format with Site Tabs**
     If the remote data is in text format, the data from each remote site will be displayed under a separate site tab. To view data from a particular site, click on the appropriate tab.



   - **Table format**
     If the report or lab is available in table format, CPRS will return data from all of the sites in a single table. The "facility" column indicates where the data in a particular row was collected. The table can be sorted by facility or by any other column heading (alphabetically, numerically, or by date) by clicking on the appropriate heading. Clicking on the heading again will sort the table in inverse order.



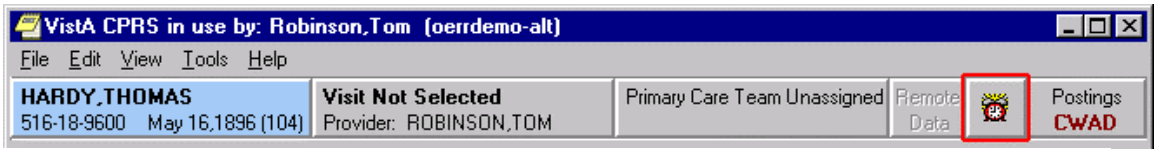
7. To see detailed information about a particular item in the table, click on that item. If detailed information is available, it will be displayed in the bottom-half of the screen. To select multiple rows, press and hold the **Shift** or **Control** key.

The Reminders Button

The CPRS GUI includes functionality from Clinical Reminders. Reminders are used to aid physicians in performing tasks to fulfill Clinical Practice Guidelines and periodic procedures or education as needed for veteran patients.

Note: For more detailed information on Reminders, refer to the *Clinical Reminders Manager Manual* and the *Clinical Reminders Clinician Guide.*

The Reminders button highlighted in red below shows you at a glance whether the patient has reminders that are due.



By observing the color and design of the icon on the Reminders button, the user receives immediate feedback on the most important type of Reminders available for the selected patient. Clinical Coordinators can set Reminders to be evaluated when you enter the chart or

they can set it to evaluate the Reminders only after you click the Reminders button or the Reminders drawer.

The following icons could be visible on the Reminders button:

 Due: The patient meets all the conditions for the reminder and the appropriate amount of time has elapsed.

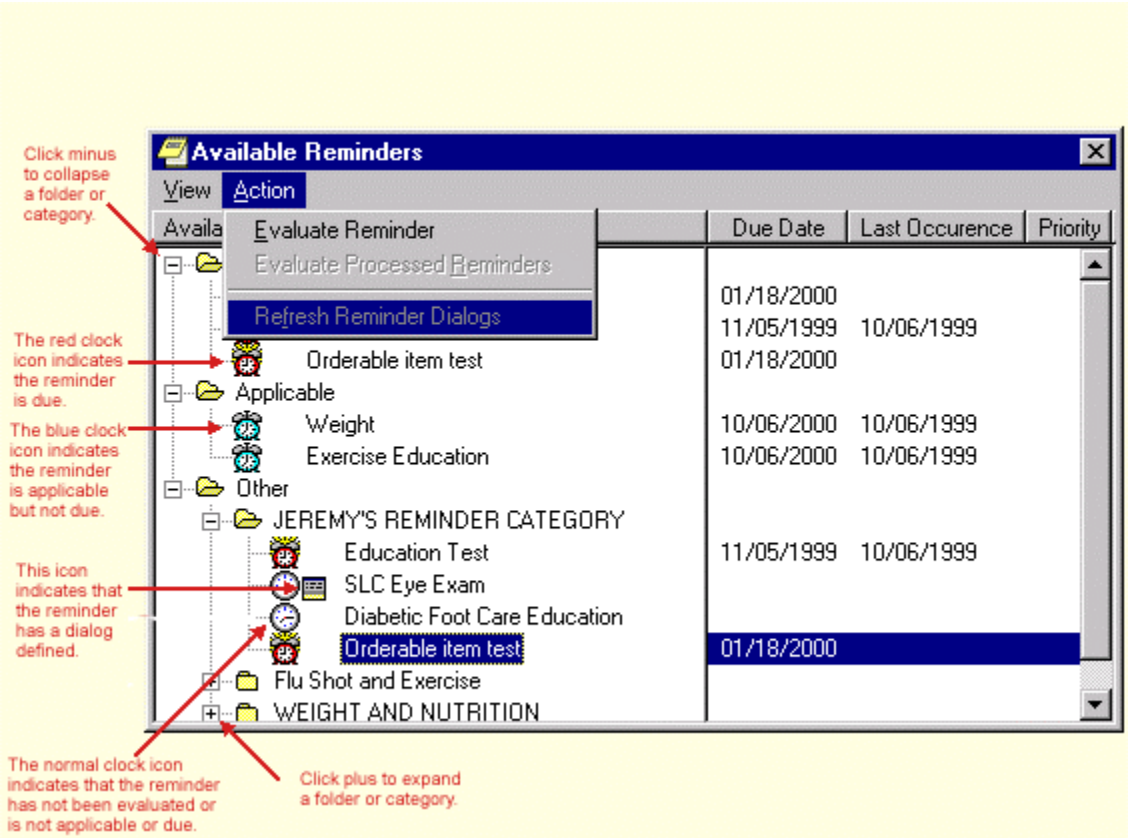
 Applicable: The patient meets all the conditions for the reminder, but the appropriate time has not elapsed. For example, a flu shot is given once a year, but it has not been a year yet.

 Other: Reminders have been defined, but were not specifically evaluated for the selected patient. An important education topic might be placed in Other.

 Question Mark: A question mark on the Reminders button indicates that the reminders have not yet been evaluated. This appears when the patient's chart is first opened to a tab other than the Cover Sheet. Click the Reminders button or the Reminders drawer on the Notes tab to evaluate the reminders.

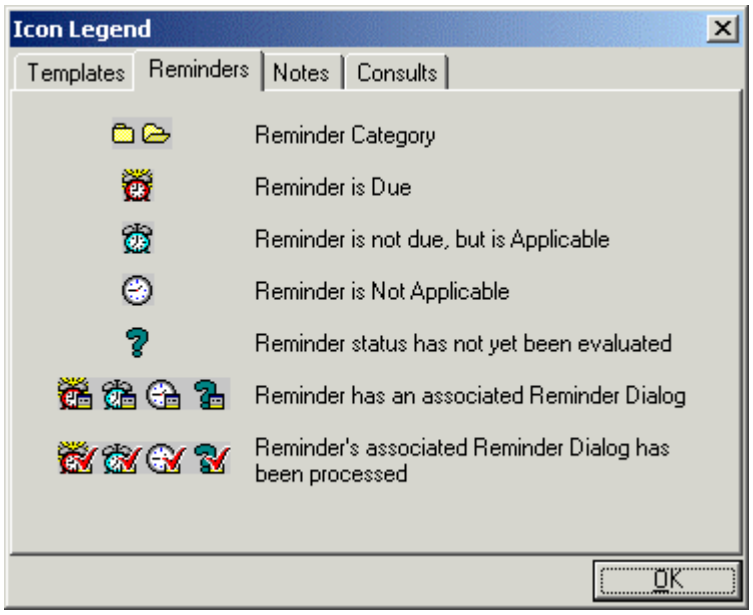
 Grayed-out Alarm Clock: This icon means that there are no due nor applicable reminders, nor are there any reminder categories available.

If you click the button, you will be shown a branched or "tree" view of the patient's reminders such as the one shown below. The icons are also used in the tree view to identify the type of reminders.



Additional information on Reminders is located in the Cover Sheet section of this manual.

The Reminders tab on the Icon Legends dialog includes a description and explanation of the different icons that appear on the Reminders tree view. To access the Icon Legend, click View | Reminder Icon Legend | and the Reminders tab.



Patient Postings (CWAD)

Postings are a special type of Progress Notes. They contain critical information about a patient that hospital staff need to be aware of. The Postings button is visible on all tabs of the patient chart. It is located in the upper right corner of the dialog. The button is labeled Postings, and if a patient has postings, letters also appear on the button showing which categories of postings the a patient has:

- **Crisis Notes** (C) – Cautionary information about critical behavior or health of a patient. *Example: Suicidal attempts or threats.*
- **Warnings** (W) – Information about a patient of which medical center personnel need to be aware. *Example: Patient can be violent.*
- **Adverse Reactions/Allergies** (A) – Posting that tells staff about medications, foods, and other conditions to which the patient is allergic or may have an adverse reaction. *Example: Patient allergic to penicillin and latex.*
- **Directives** (D) – Also called Advanced Directives, Directives are recorded agreements that a patient and/or family have made with the clinical staff. *Example: DNR (Do Not Resuscitate) directive on file.*

For example, if the selected patient has a Crisis Note, a “C” shows on the button. If the patient has a Directive, a “D” appears on the button.

You can access the full text of a posting through the Postings button from any tab, or from the Cover Sheet, you can select a posting from the Adverse Reaction/Allergies area or the Postings area.

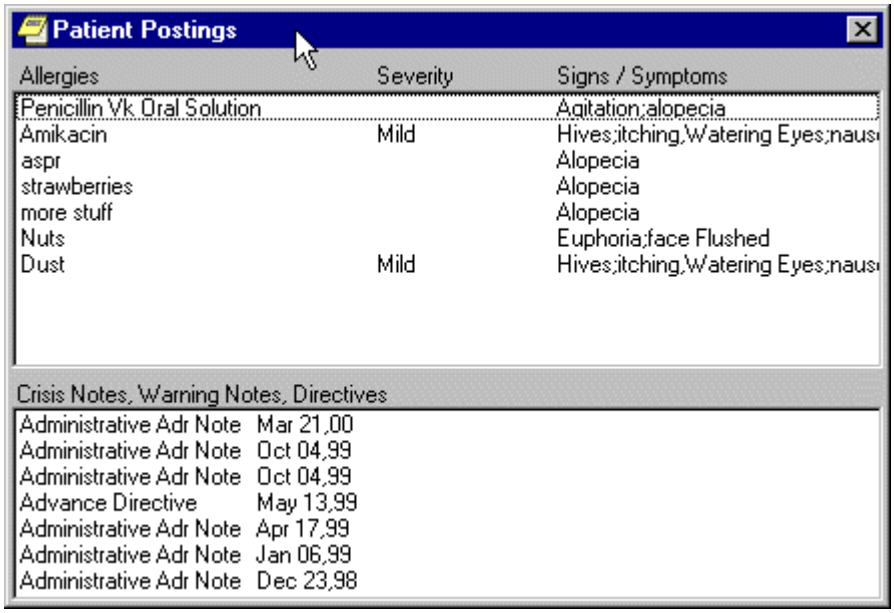
To create a new posting, you simply write a new progress note, and in the Progress Note Title drop-down list, select one of the following:

- Adverse Reaction/Allergy

- Clinical Warning
- Crisis Note
- Directive
- Warning

Viewing Postings

You can view postings from any tab using the Postings button.



To see the full text of the note through the Postings button, use the following steps:

1. Click the **Postings** button. A dialog containing all postings for the selected patient appears. The postings are divided into Adverse Reactions/Allergies and the other categories.
2. Click a posting to see a detailed explanation. A new window will appear with the full text of the posting in it as shown below.
3. When you finish with the posting, close the window with the full text by clicking the close button in the upper right corner of the window.

Electronic Signature

With CPRS you can electronically "sign" orders and documents. You can ask your clinical coordinator to set you up with an electronic signature code.

You must keep your signature code secret and use it properly to help keep an accurate medical record.

Generally, orders and documents such as notes and discharge summaries require an electronic signature. Orders are often signed as a group. Documents can be signed either individually or as a group if they have not been signed. You may have to use the **View | Unsigned Notes** (or Unsigned Discharge Summaries) to see if there are any notes you have not signed for a patient.

You will automatically be prompted for a signature when you do any of the following:

Select **File | Review / Sign Changes...** to see the orders you have entered for this patient in this session.

- Select **File | Select New Patient...**to close this record and open a new record.
- Select **File | Exit** or click the close button.

An option to sign is also available on the Orders, Notes, Consults, and D/C Summary tabs. It is usually under the Action menu or you can right-click in the main text area of a document or on a highlighted order.

Identify Additional Signers

With this feature, you can select others you want to sign this note. An alert will then be sent to that person that this note is ready for them to sign.

Identify Additional Signers helps you ensure that team members see a note. For example, one psychiatrist might identify another psychiatrist to sign the note to ensure that he or she agrees with an assessment.

To identify additional signers, use these steps:

1. After you have signed the note, select **Action | Identify Additional Signers**.

   -or-

   Right-click in the main text area and select **Identify Additional Signers**.
2. To identify a signer, locate the person's name (scroll or type in the first few letters of the last name) and click it.
3. Repeat step 2 as needed.
4. (Optional) To remove a name click the name under **Current Additional Signers** and click **Remove**.
5. When finished, click **OK**.

Add to Signature List

With Add to Signature List, you can place notes or discharge summaries for the same patient on a list where you can sign them all simultaneously.

This menu item might be used with View | Unsigned Notes or View | Uncosigned Notes to place a number of notes you will sign at the same time. To sign them, you would use File | Review / Sign Changes.

To add an item to your signature list, click on Add to Signature List after completing or reviewing a note.

Sign Selected Orders

With CPRS, you can enter several orders and then sign them all simultaneously.

Orders are not released to services or activated until they are signed. There are two exceptions to this rule:

- Orders that can be designated as "signed on chart"
- Generic orders that don't require a signature

Remember that you also can use File | Review / Sign Changes...to see a summary of what you have entered for this patient in this session and sign those orders and documents that have not yet been signed.

To sign a number of orders, use these steps:

1. On the Orders tab, highlight the orders you want to sign. Use SHIFT and CTRL click in combination to select the desired orders.
2. To select individual orders, use CTRL click.
3. To select a range of items, click the order at the beginning of the range; then hold down the SHIFT key and click the order at the end of the range to select those two orders and all the orders between them.
4. Select **Action** | **Sign Selected**.
   -or-
   Right-click and select **Sign**.
5. Click **OK**.

Review / Sign Changes

After you write orders or documents, such as progress notes, reports, or health summaries, you must "sign" them. Orders are not activated until they are signed. There are two exceptions to this rule:

- Orders that can be designated as "signed on chart"
- Generic orders that don't require a signature

The Review / Sign Changes screen shows you the orders and documents that you have entered for this patient during the current session. Each item that requires a signature has a check box in front of it.

All of the items that are checked will be signed when you enter your code. To deselect items, click the check box. Then, you enter your signature code to sign the orders and documents that are checked.

To electronically sign orders or documents, follow these steps:

1. To sign orders or documents and stay in this patient record, select **File** | **Review** / **Sign Changes....**
   a. To sign and move on to another patient, choose **File** | **Select New Patient**.
   b. To sign and exit CPRS entirely, choose **File** | **Exit**.
2. Deselect any items that you do not want to sign by clicking the check box in front of them.
3. Enter your electronic signature code.

   Note: If you don't have an electronic signature code, check with your clinical application coordinator.
4. Click **OK**.

What signing options you have, such as Save with Signature or No Signature Required, depends on the key you have been given. The signing options you can use for orders will be displayed at the bottom of the Review / Sign Changes dialog. Your clinical coordinator assigns your keys.

Sign Documents Now

After completing a note or discharge summary, you can immediately sign that document. The Sign Note Now and Sign Discharge Summary Now menu items will let you sign the current note.

These options sign only the current document you have created or edited.

Note: Notes and Discharge Summaries cannot be altered once they are signed. You can include additional signers of the document.

To sign the current note or discharge summary, use these steps:

1. Select **Action** | **Sign Note Now** (or Sign Discharge Summary Now).
2. Right-click in the document area and select **Sign Note Now** (or **Sign Discharge Summary Now**).
3. In the dialog that appears, type in your electronic signature code.

   Note: If you don't have an electronic signature code, check with your clinical application coordinator.
4. Click **OK**.

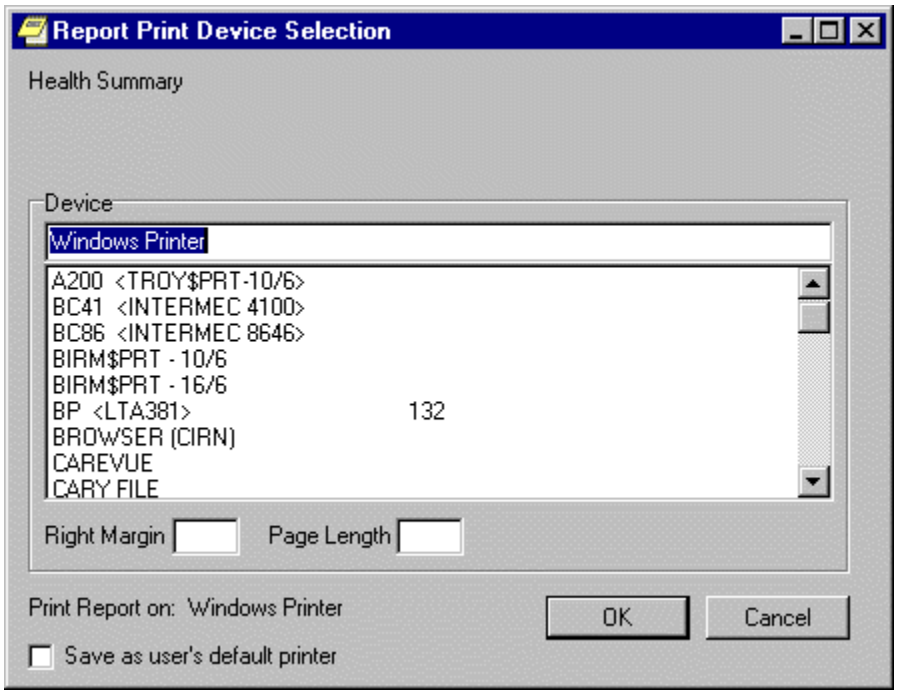
Printing from Within CPRS

You can print most reports, notes, and detailed displays from within the CPRS GUI.

To print graphics and charts, you will need to print to a Windows printer. Otherwise, for text documents, you can print to either a Windows or a VistA printer. The printer language used by Windows printers can accommodate graphics, while the language used by VistA printers cannot.

You can also now print graphics on a Windows printer from the Labs tab and the Vitals screen. You can use **File | Print Setup...** to set up a preferred printer for the current session and save it as the default for the user.

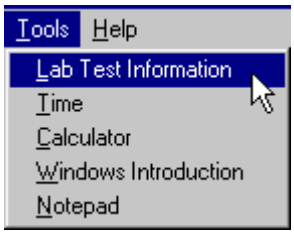
The dialog box shown below comes up when you select **File | Print** from the Notes tab. A similar dialog, without the Chart copy / Work copy option appears for items on other tabs. Many report boxes now have Print button on them to make it easier for you to print the information you need.



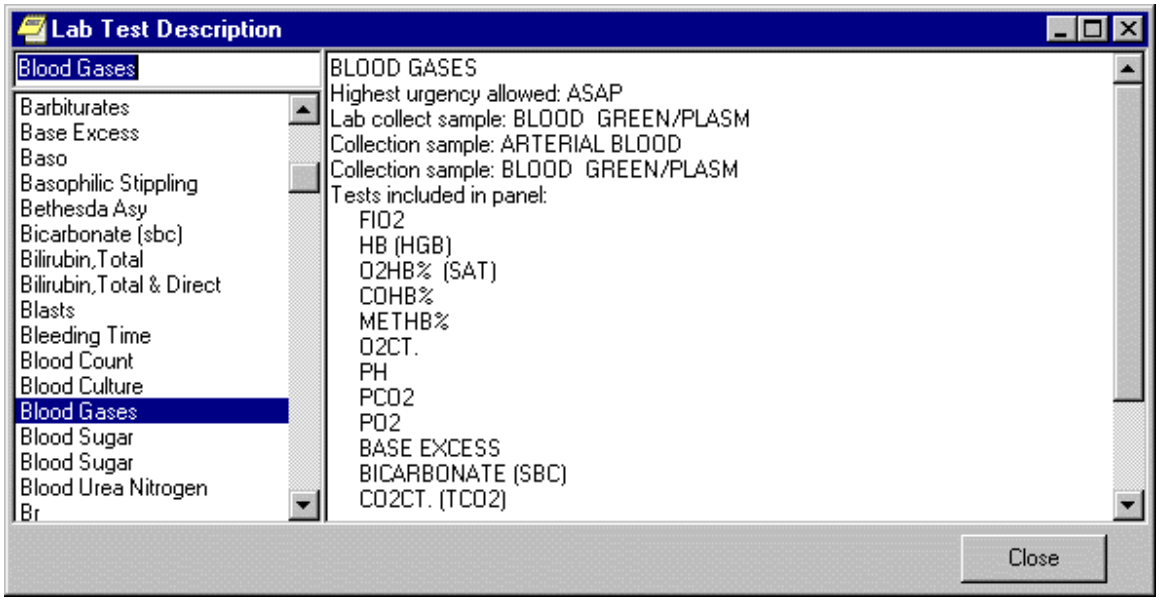
Normally, you do not need to enter a right margin or page length value. These values are measured in characters and normally are already defined by the device. You will also still have the options to print your regular tasked jobs.

Tools from Within CPRS

The Tools menu contains one standard item called “Lab Test Information.” Your site manages the remaining items on the Tools menu.



Selecting **Tools |Lab Test Information** menu option brings up the following dialog. Scroll through the list of lab test in the left field. When you select one, the results for that test will be displayed in the right field.

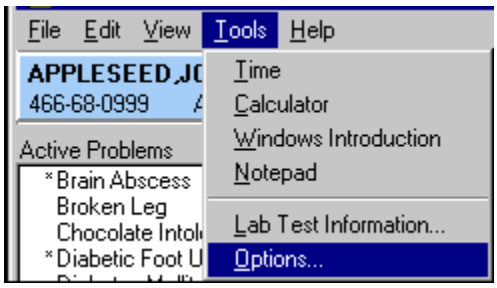


The Tools menu is a place where you can place items that you want to have quick access to when within CPRS. For example, you might want to have an item for a word processor or a local program you use.

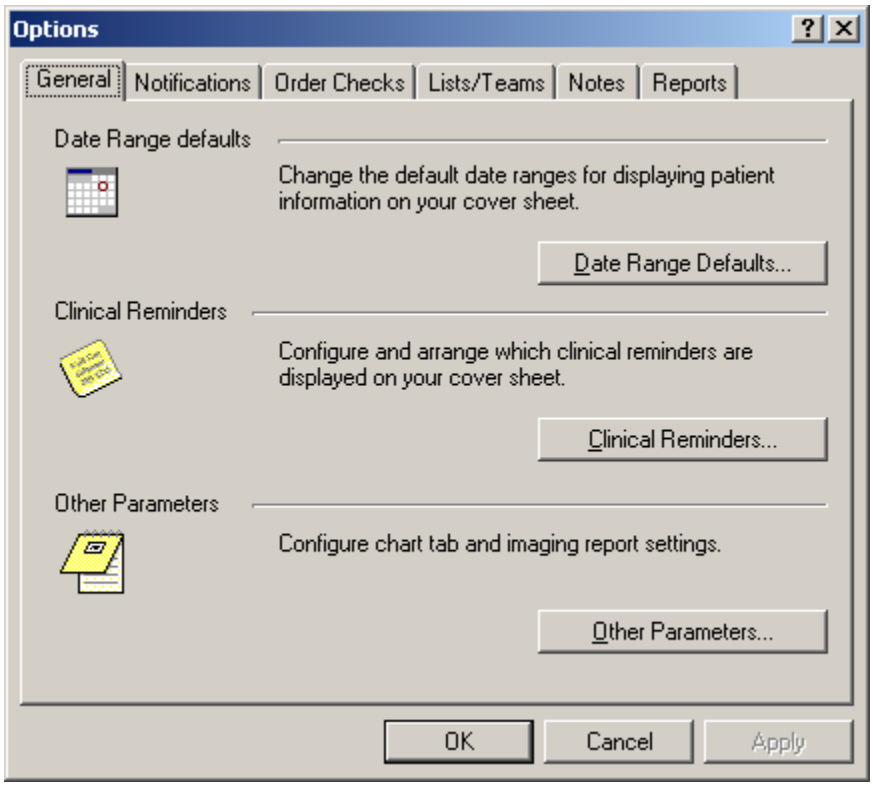
The tools menu is a menu that you can customize. It can contain menu items to take you to other parts of VISTA, to local policies, to word-processing programs, to the Web, or to whatever your site chooses to put on this menu. An option for adding items to the Tools menu is on the CPRS Configuration Menu (Clin Coord). Talk to your Clinical Coordinator if you wish to have something added.

Personal Preferences

You can change many of the settings that control the way CPRS works. The Options choice on the Tools menu contains dialogs that allow you to change which notifications and order checking messages you get, manage team and personal lists, assign your default patient selection settings, and modify your default tab preferences. To access the personal preferences settings, click **Tools | Options** from any CPRS tab.



The Options dialog consists of a number of tabs, each of which allows access to a category or type of preference settings.

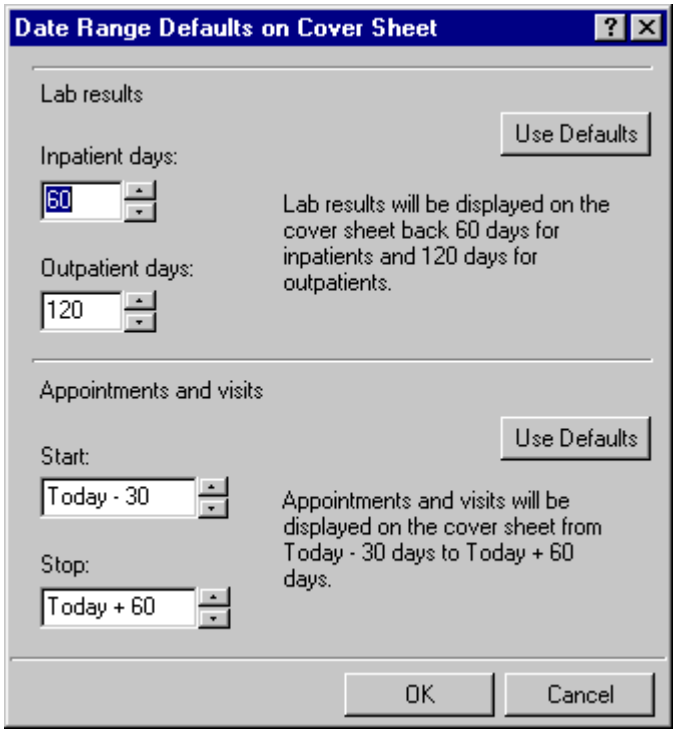


General tab

The General tab includes the **Date Range Defaults…**button which allows you to limit the date range for lab results as well as appointments and visits that appear on the cover sheet, the **Clinical Reminders…** button which allows you to configure and arrange which clinical reminders are displayed on the cover sheet, and the **Other Parameters…**button which allows you to set which tab is active when CPRS starts, and limit the number of imaging reports that are available from the Reports tab. The buttons on the General tab are explained in more detail below.

Date Range Defaults…

Click on **Date Range Defaults…** to set how long lab results, appointments, and visits will be displayed on the Cover Sheet.



Clinical Reminders…

Click on Clinical Reminders… to configure and arrange which clinical reminders are displayed on the Cover Sheet.

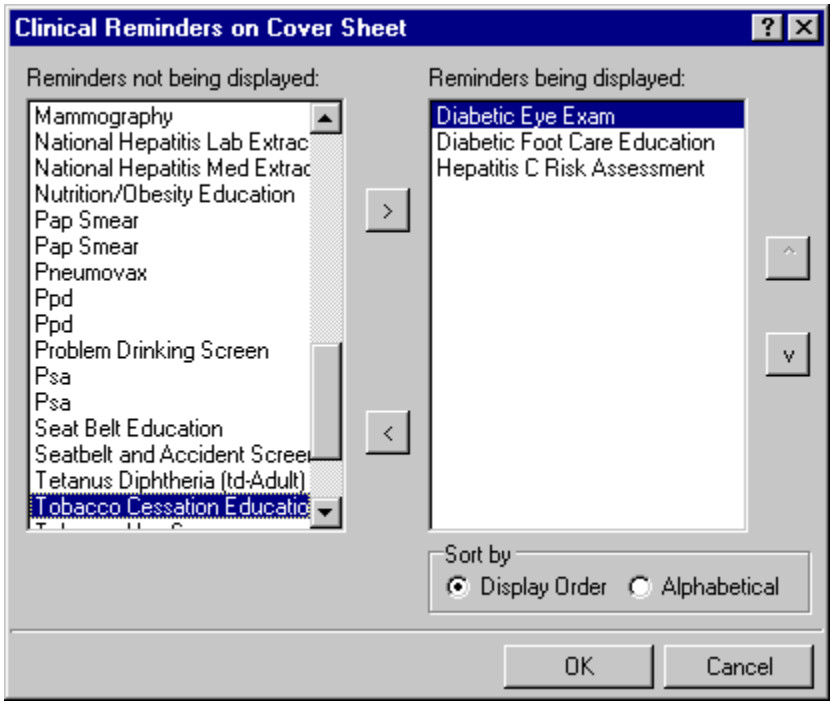
Based on the setting of the parameter ORQQPX NEW REMINDER PARAMS, you will see one of two dialogs for configuring and arranging clinical reminders on your coversheet. If this parameter is set to "Off," you will see the "Clinical Reminders on Cover Sheet" dialog. If the parameter is set to "On," you will see the "Clinical Reminders and Reminder Categories Displayed on Cover Sheet" dialog. Your Clinical Coordinator sets the ORQQPX NEW REMINDERS PARAMS parameter.

Clinical Reminders on Cover Sheet

From the dialog, highlight an item in the "Reminders not being displayed" field and then click the Add arrow ">" to add it to the "Reminders being displayed" field. You may hold down the Control key and select more than one reminder at a time. When you have all of the desired reminders in the "Reminders being displayed field", you may highlight a reminder and use the up and down buttons on the right side of the dialog to change the order in which the reminders will be displayed on the Cover Sheet.

Sort by

Select Display Order to display the reminders in the order that you choose. Click Alphabetical to have the reminders displayed in alphabetical order.

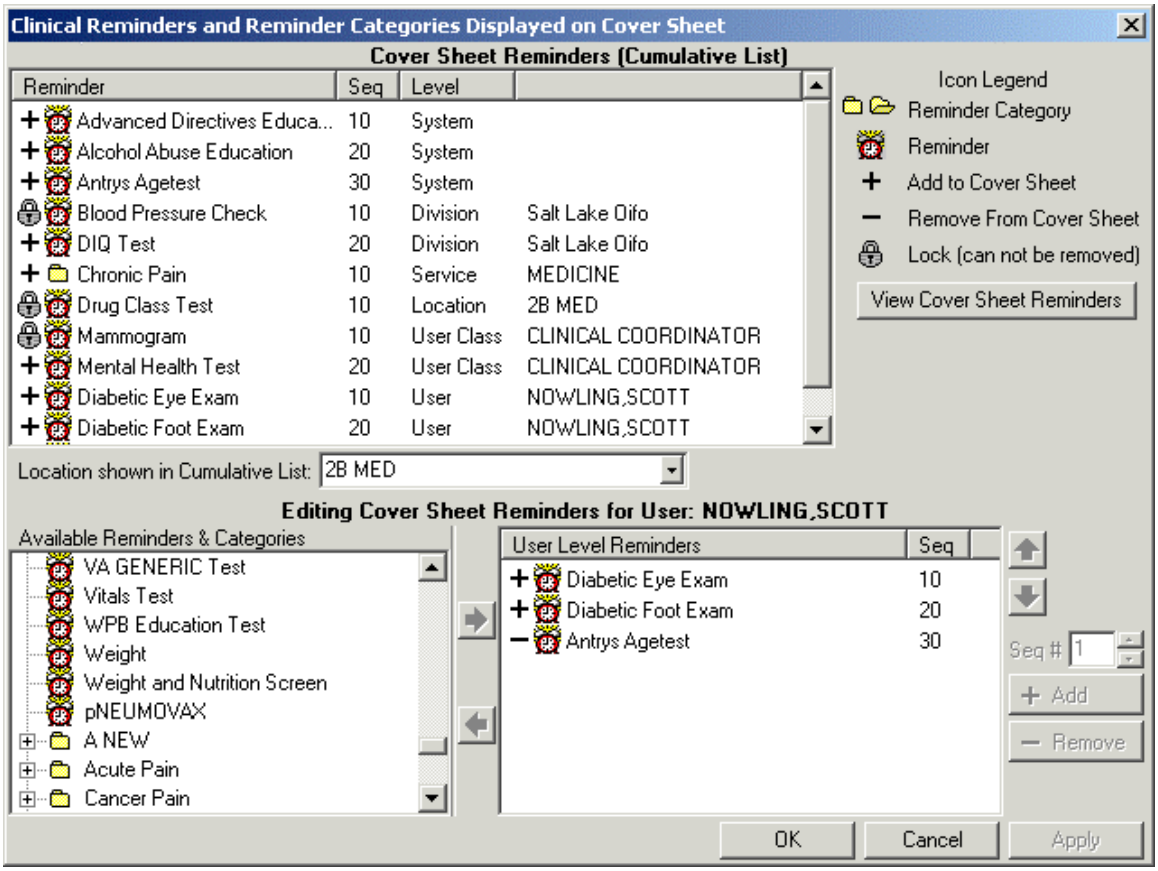


Clinical Reminders and Reminder Categories Displayed on Cover Sheet

This advanced dialog displays reminders in a way that allows the user to better manage the reminders that are displayed on the Cover Sheet. The dialog consists mainly of three large list fields. The "Cover Sheet Reminders (Cumulative List)" field displays selected information on the Reminders that will be displayed on the Cover Sheet. The "Available Reminders & Categories" field lists all available reminders and serves as a selection list. The "User Level Reminders" field displays the reminders that you have added to or removed from the cumulative list.

You may sort the reminders in the "Cover Sheet Reminders (Cumulative List)" field by clicking on any of the column headers. Click on the Seq (Sequence) column header to view the reminders in the order in which they will be displayed on your Cover Sheet.

An icon legend is displayed to the right of the "Cover Sheet Reminders (Cumulative List)" field. A folder icon represents a group of Reminders while a red alarm clock represents an individual Reminder. A Reminder with a plus sign in the first column has been added to the list while a Reminder with a minus sign in the first column has been removed from the list. The user cannot remove reminders with a padlock icon in the first column.



Cover Sheet Reminders (Cumulative List)

The Level column of the "Cover Sheet Reminders (Cumulative List)" field displays the originating authority of the Reminder, which can include System, Division, Location, User Class, and User. Reminders on this list that display a small gray padlock icon at the beginning of the line cannot be removed. These Reminders are mandatory. The Seq (Sequence) column defines the order in which the Reminders will be displayed on the Cover Sheet. If there are two or more Reminders with the same sequence number, the Reminders will be listed by level (System, Division, Service, Location, User class, User).

Location shown in Cumulative List

Click on this drop-down box and select a location. The Reminders assigned to that location appear on the Cumulative List.

Available Reminders & Categories

This field displays all of the Reminders and Categories available to the user. Notice that the reminder name is in parentheses after the print name. Categories are groups of related Reminders that can be added as a group. Individual reminders within a category can be removed from the User Level Reminders field. Highlight a Reminder or Category from the field and click the right arrow to add them to the User Level Reminders field.

User Level Reminders

This field displays all of the Reminders selected by the user. To add a Reminder to your User Level Reminders, highlight the desired Reminder in the Available Reminders & Categories field and click the right arrow button. To delete a Reminder from your User Level Reminders field, highlight the Reminder in the User Level Reminders field and click the left arrow.

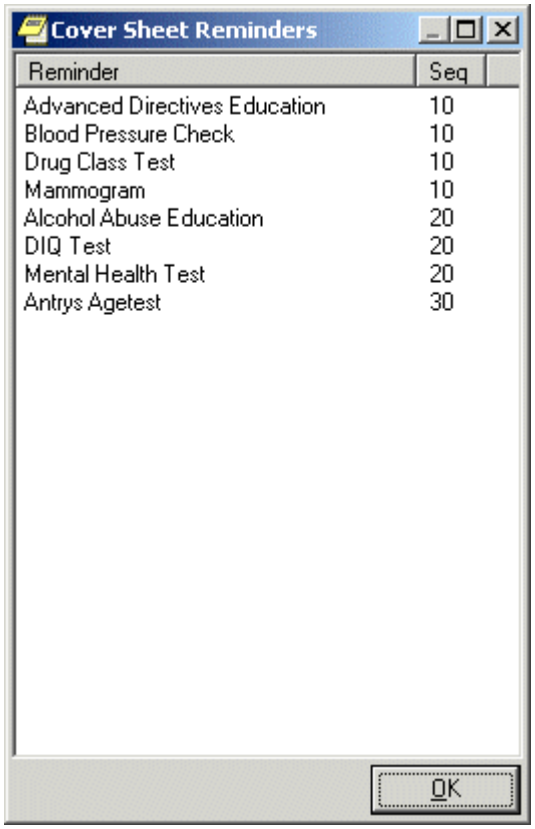
You may determine the order in which the Reminders will be displayed on the Cover Sheet by changing the Reminder's sequence number. For example, to place a Reminder at the top

of the Reminders list, assign it a number less than 10. To change the order of User Level Reminders, highlight Reminders and click the up arrow or down arrow until the desired order is achieved.

You may remove any or all non-mandatory Reminders assigned at any level by adding the Reminder to your User Level and then clicking the Remove button.

Cover Sheet Reminders

Once you have the cumulative list, as you want it, click View Cover Sheet Reminders to view how the reminders will be displayed on your Cover Sheet for the specified locations.



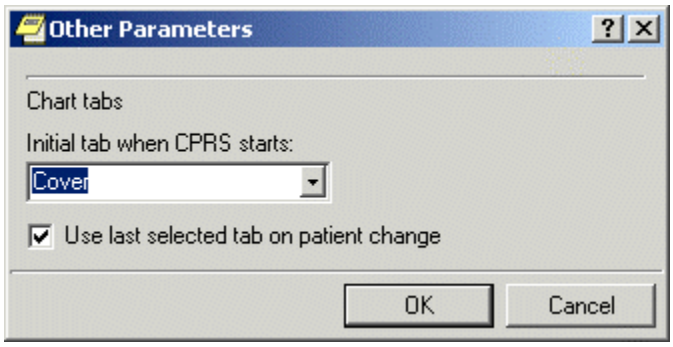
Once you have made all of the desired changes to the Reminders that will be displayed on the Cover Sheet, click OK.

Other Parameters…

To set chart tab preferences click **Other Parameters**. This option also allows you to set restrictions on the number of image reports you want to display.

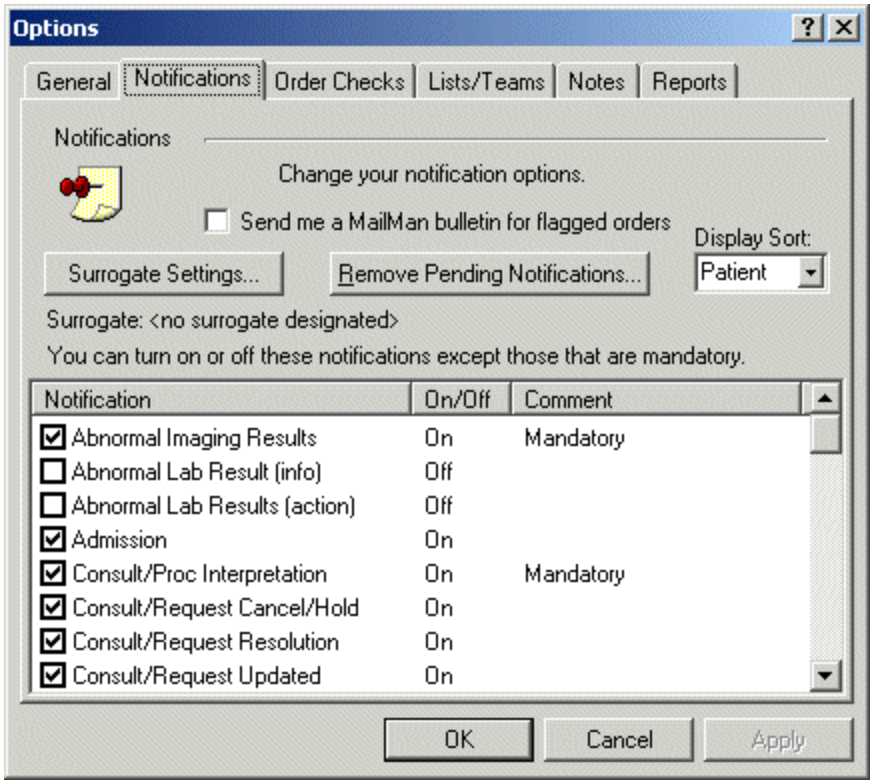
Chart tabs

Click on the drop-down field and select the chart tab with which CPRS should open. Click on the check box if you want CPRS to remain on the last selected tab when you change patients.



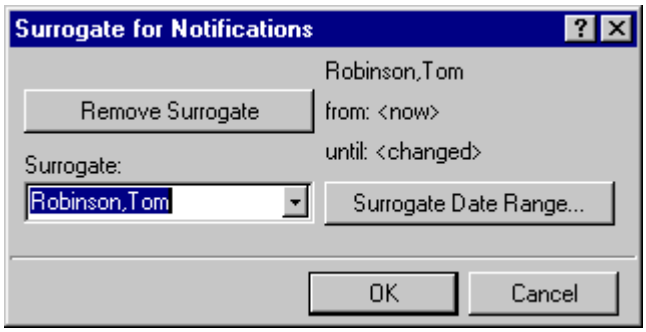
Notifications tab

This tab allows you to change your notification options. Click the check box if you wish to have MailMan send you a bulletin for flagged orders.

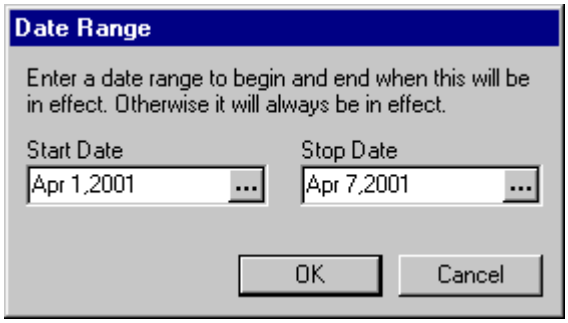


Surrogate Settings…

To set a surrogate, click on **Surrogate Settings…** From the Surrogate for Notifications dialog, select a surrogate from the drop-down list. When saved, the surrogate information is displayed on the Notifications tab.



To set a surrogate date range, click on **Surrogate Date Range…** From the Date Range dialog, click on the … button and select a start date and a stop date. You may also select a start time and a stop time for the surrogate. When saved, the surrogate date range information is displayed on the Surrogate for Notifications dialog.



Remove Pending Notifications…

Click on the **Remove Pending Notifications** button and then on **Yes** on the Warning dialog to clear all of your current pending notifications. This button is enabled only if you are authorized to use it.

Display Sort

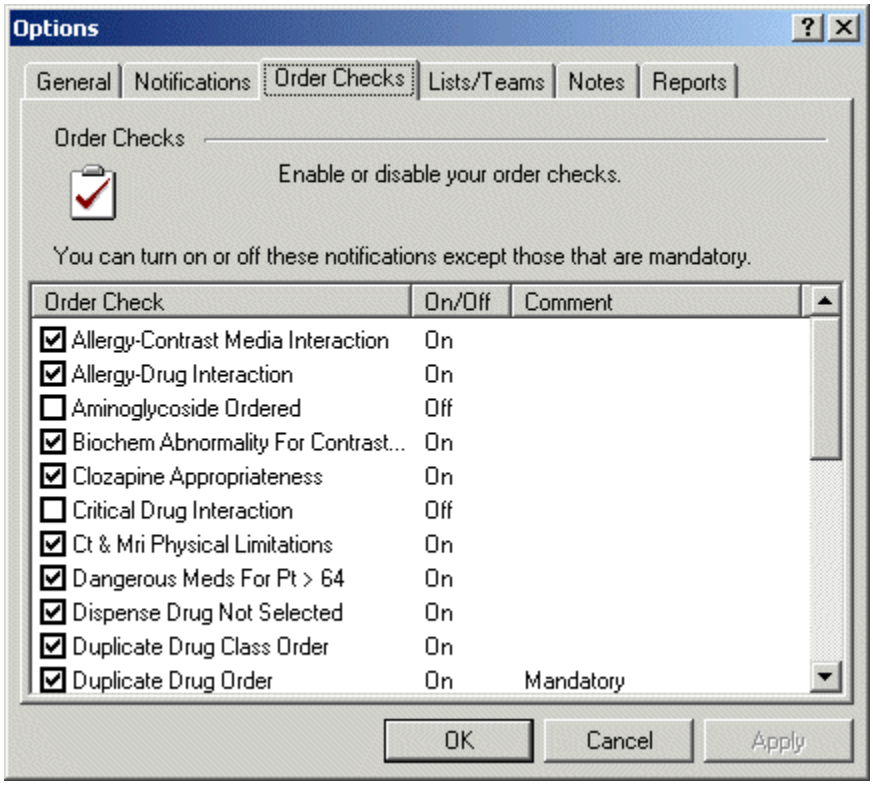
Click on the Display Sort drop-down field to select the sort method for your notifications. Choices include Patient, Type, and Urgency.

Notifications list

Click the check box next to any notification to enable or disable it. Notifications with "Mandatory" in the Comment column cannot be turned off or disabled. Click the heading to sort notifications so that you can see which are turned on and which are turned off.

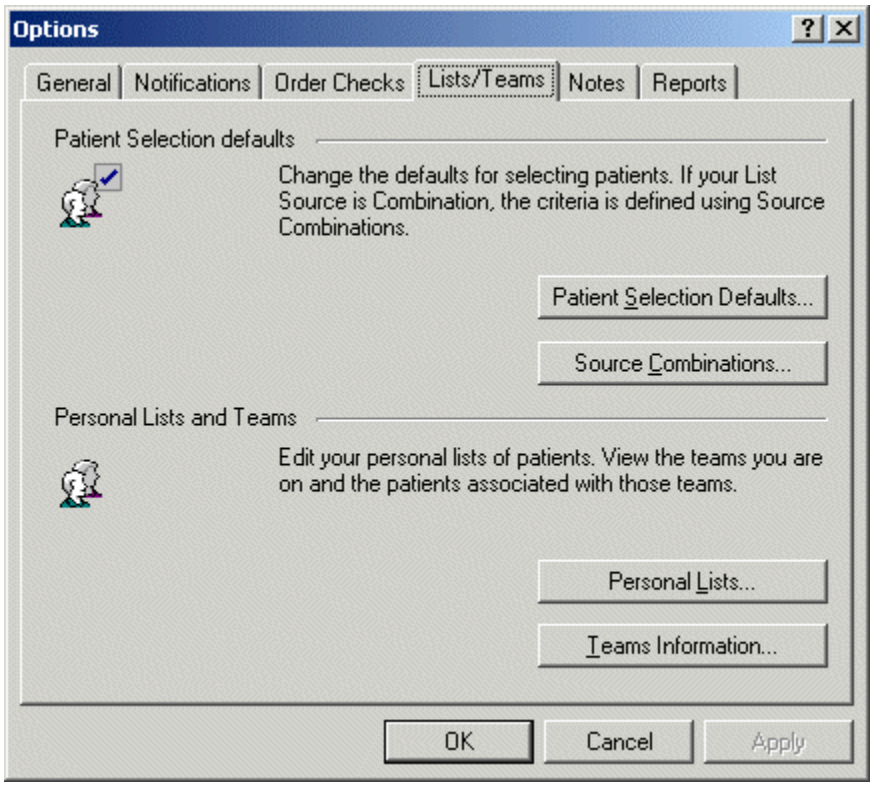
Order Checks tab

Click the check box next to any order check to enable or disable it. Order checks with "Mandatory" in the Comment column cannot be turned off or disabled. Click the heading to sort order checks so that you can see which are turned on and which are turned off.



Lists/Teams tab

The Lists/Teams tab allows you to set defaults for selecting patients. It also contains your personal lists and the teams of which you are a member.



Patient Selection Defaults…

Click on **Patient Selection Defaults…** to change your defaults for selecting patients. Click a radio button in the List Source group. If you select Combination, you will be able to select from more than one source. After selecting a list source, click the appropriate drop-down button (or buttons if Combination is selected) and select the criteria for that source. If you select Clinic or if Clinic is one of the sources in your combination of sources, you will need to select a clinic for each applicable day of the week. If you do not work in any clinic on a particular day, leave the field for that day empty.

Click a radio button in the Sort Order group to determine the sort order for the patients. If an item is dimmed, it is not available with the list source(s) you have selected.

To display patients who have clinic appointments within a specific date range, click the selection buttons. The Start and Stop fields denote the number of days before or after today that appointments should be displayed.

The defaults that are set here are used when you select patients from the Patient Selection dialog in the CPRS chart. Therefore, if you choose Ward, it will display the patients for the ward you have set as your default and if you choose Clinic, it will display the clinic patients for that day.

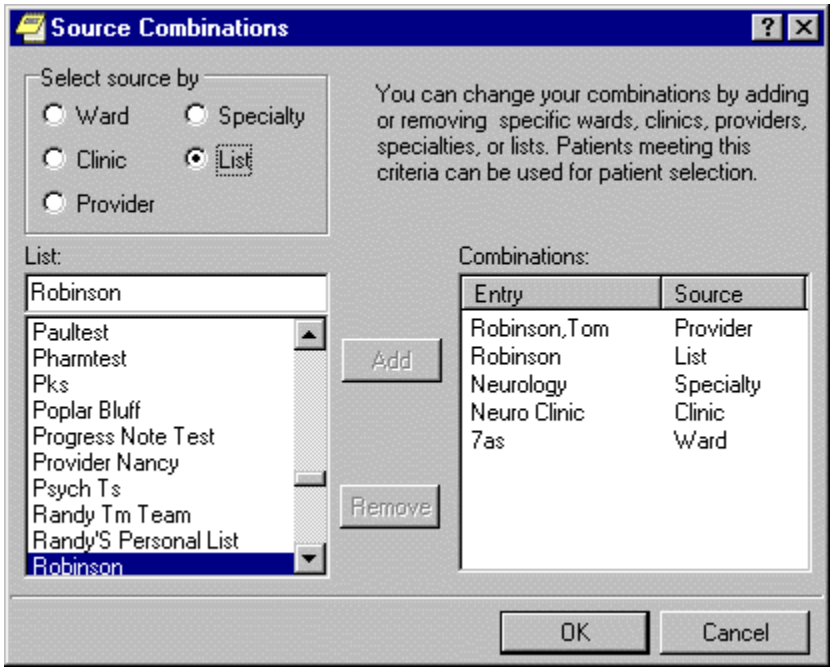
Source Combinations…

Click Source Combinations… to edit or create a list of sources from which your patients can be selected. You can change you combinations by adding or removing specific wards, clinics, providers, specialties or lists.

To create a source combination:

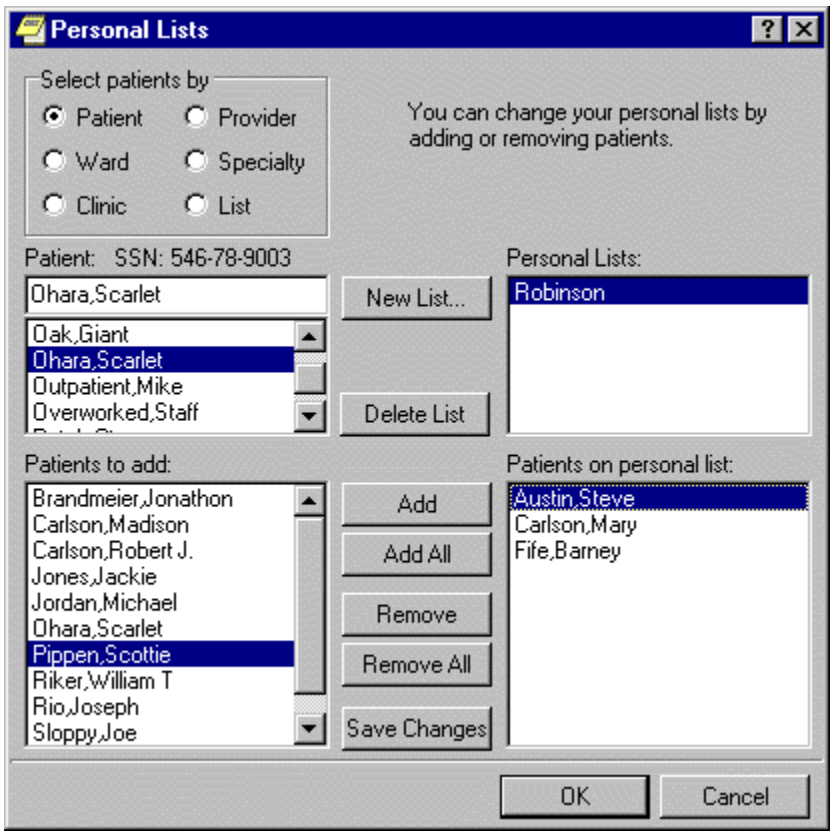
1. Click on a radio button in the "Select source by" group.
2. Click an entry in the selection field below the "Select source by" group.
3. Click **Add**.
4. Repeat steps 1 through 3 for each desired source.
5. When all desired entries are in the Combinations field, click **OK**.

You can create only one combination list. The Combination list can be set as your default using the Patient Selection dialog.



Personal Lists…

This option allows you to edit your personal lists of patients or combinations of wards, clinics, providers, specialties, or lists.



Personal Lists...

Click Personal Lists... to edit or create list of patients. To create a list, click New List... and type in a name for your list. Click a radio button in "Select patients by" group to select a method for defining patients on your list. The selection box below the "Select patients by" group lists the available choices for the selection method. The Patients to add field lists all of the patients that can be added from the particular selection method. With the desired patients in the Patients to add field, click Add (which adds the highlighted patient or patients) or Add All to copy the patients to Patients on personal list. Click Save Changes if you plan to make other changes on the Personal List dialog such as creating one or more additional Personal Lists. Click OK when you have finished making all desired changes and additions to this dialog.

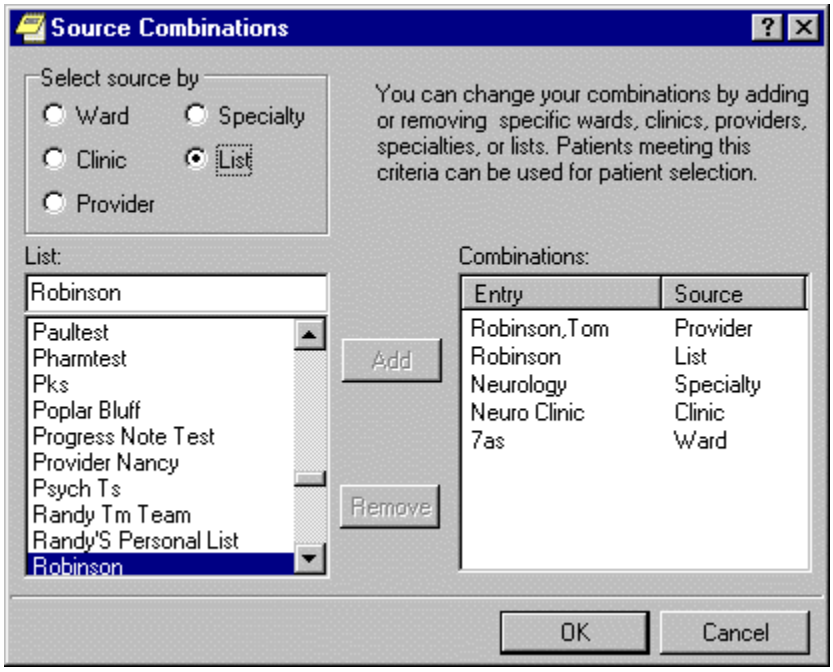
Source Combinations…

Click Source Combinations to edit or create a list of sources from which your patients can be selected. You can change you combinations by adding or removing specific wards, clinics, providers, specialties, or lists.

To create a source combination:

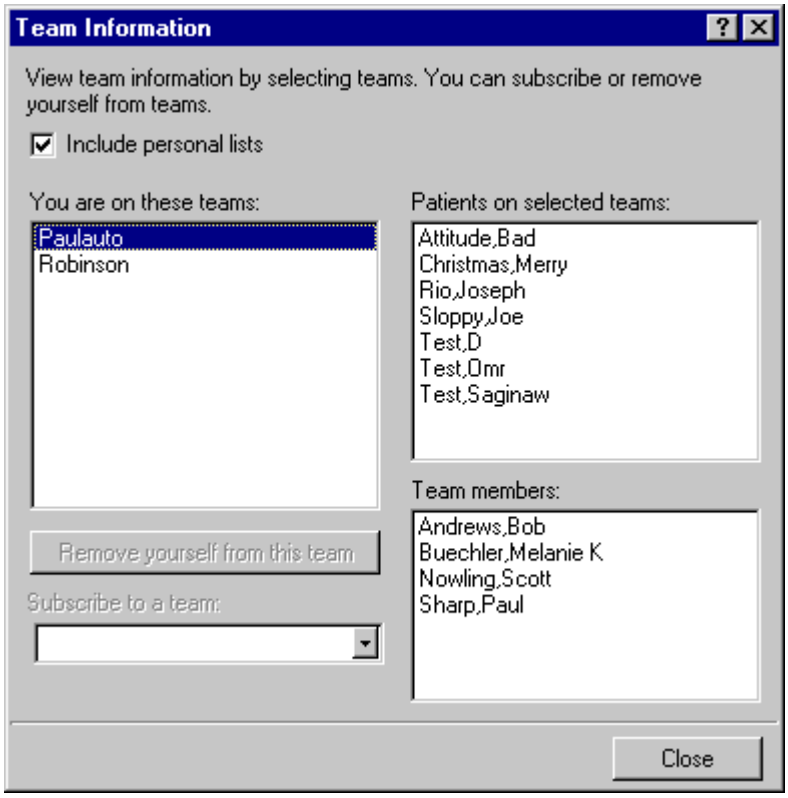
1. Click on a radio button in the Select source by group.
2. Click an entry in the selection field below the Select source by group.
3. Click Add.
4. Repeat steps 1 through 3 for each desired source.
5. When all desired entries are in the Combinations field, click OK.

You can create only one combination list. The Combination list can be set as your default using the Patient Selection dialog.



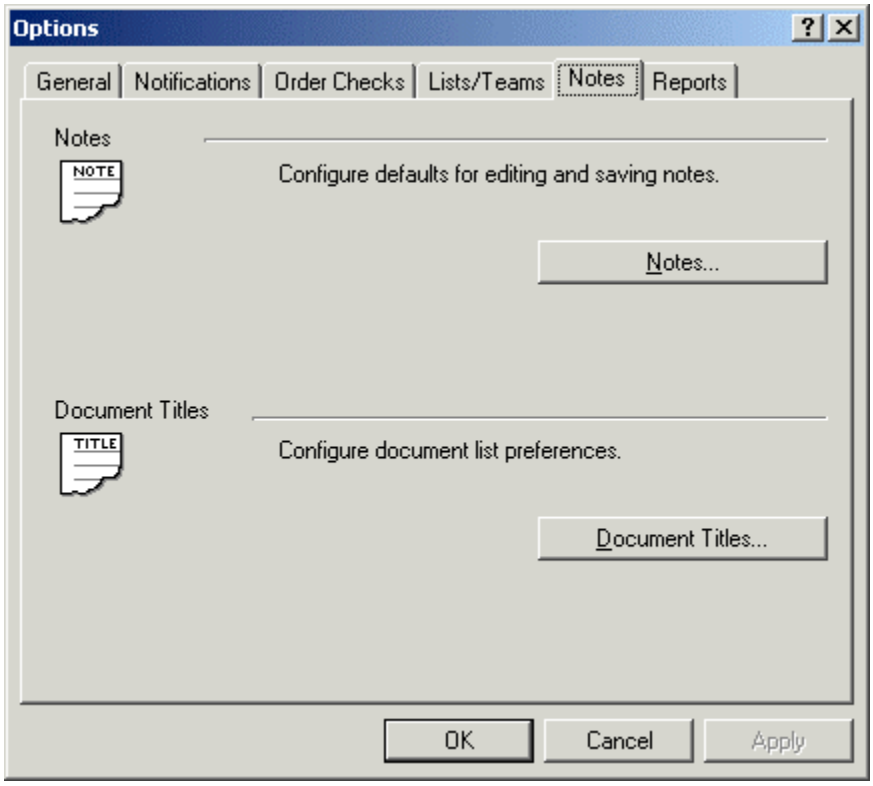
Teams Information…

This option allows you to view the teams you are on and the patients associated with those teams.



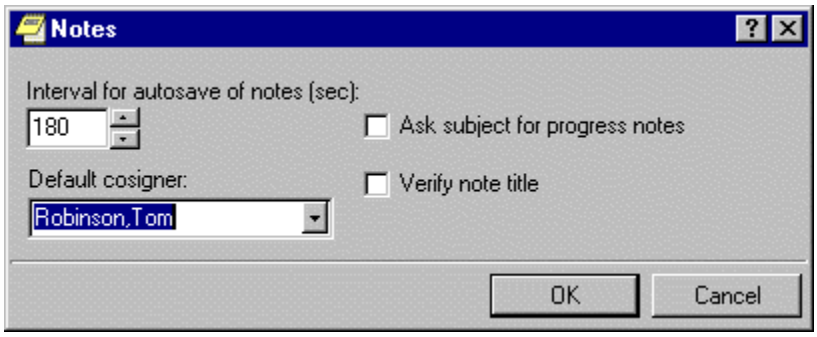
Click a team to view the patients associated with it and other team members. Click the check box to include your personal lists. Click Remove yourself from this team to remove yourself from the highlighted team. Click the drop-down button on the “Subscribe to a team” field and select a team to which you wish to be added. You can only subscribe yourself to or remove yourself from teams that have been defined as "subscribable."

Notes tab



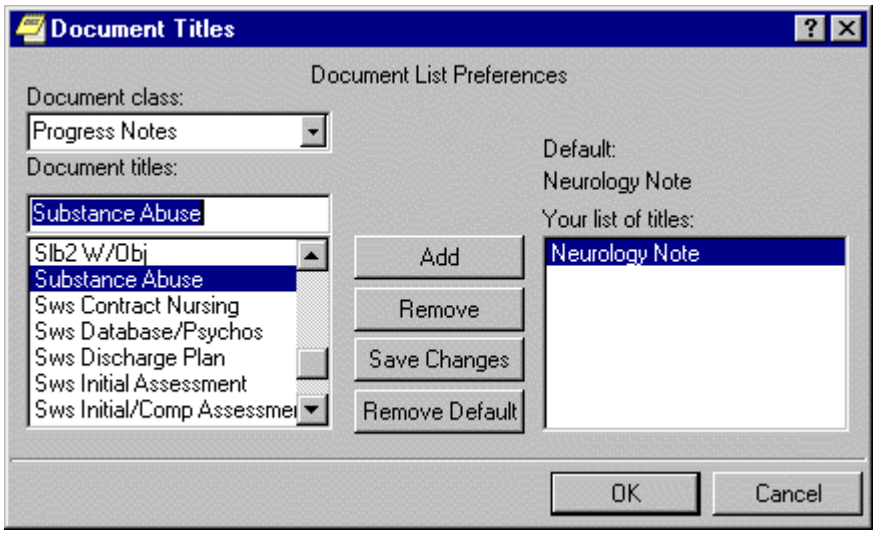
Notes…

This option on the Notes tab allows you to configure defaults for editing and saving notes. Click on the selection arrows to change the number of seconds between auto save intervals. You may also assign a default cosigner for notes by clicking on the drop-down button and selecting a provider. You may also click on the either of the two check boxes, if you wish to be prompted for a subject for progress notes and if you wish to verify note titles.



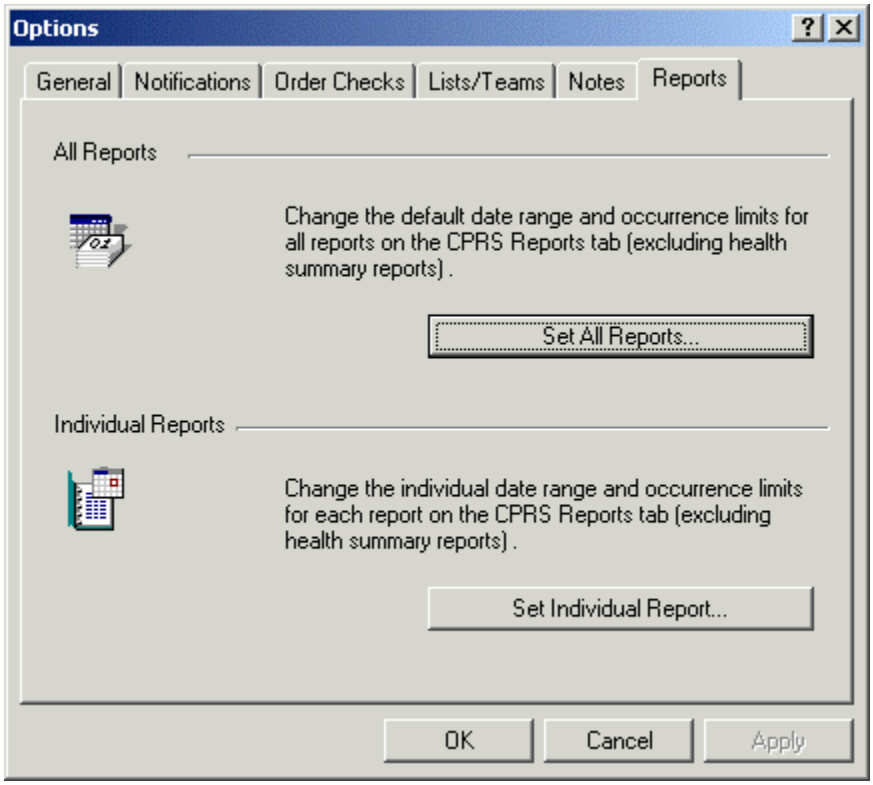
Document Titles…

You may select a personal list of document titles to be displayed for several different types of documents. Click on the drop-down button on the Document class field and select the class of document for which you would like to create a list. When you have selected a document class, the Document titles field is automatically populated with all available choices. Highlight one and click on **Add**. Hold down the Control key to select more than one title at a time. To select a title from your list as your default, highlight it and click on **Set as Default.** Click on **Save Changes** if you will be making more changes on this dialog before you click **OK**.



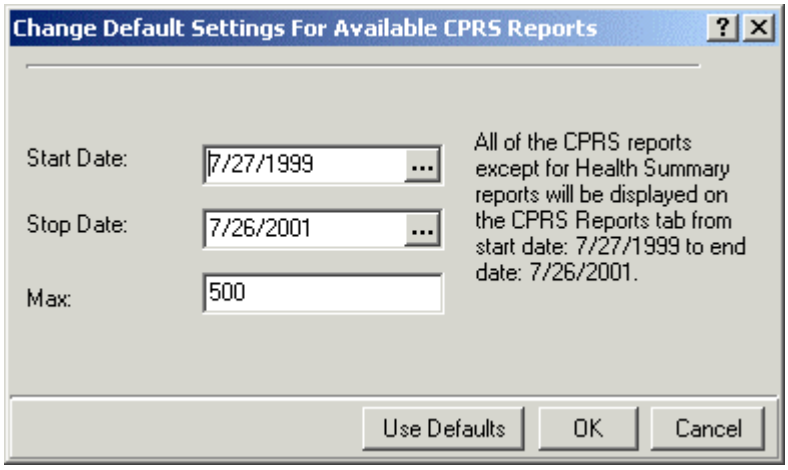
Reports tab

This tab allows you to set the date ranges and the maximum number of occurrences for CPRS reports. You can change the settings for all reports or for individual reports.



Set All Reports …

This option allows you to set a start date, a stop date, and a maximum number of occurrences for all CPRS reports. After you press the **Set All Reports…** button the "Change Default Settings For Available CPRS Reports" dialog will appear.

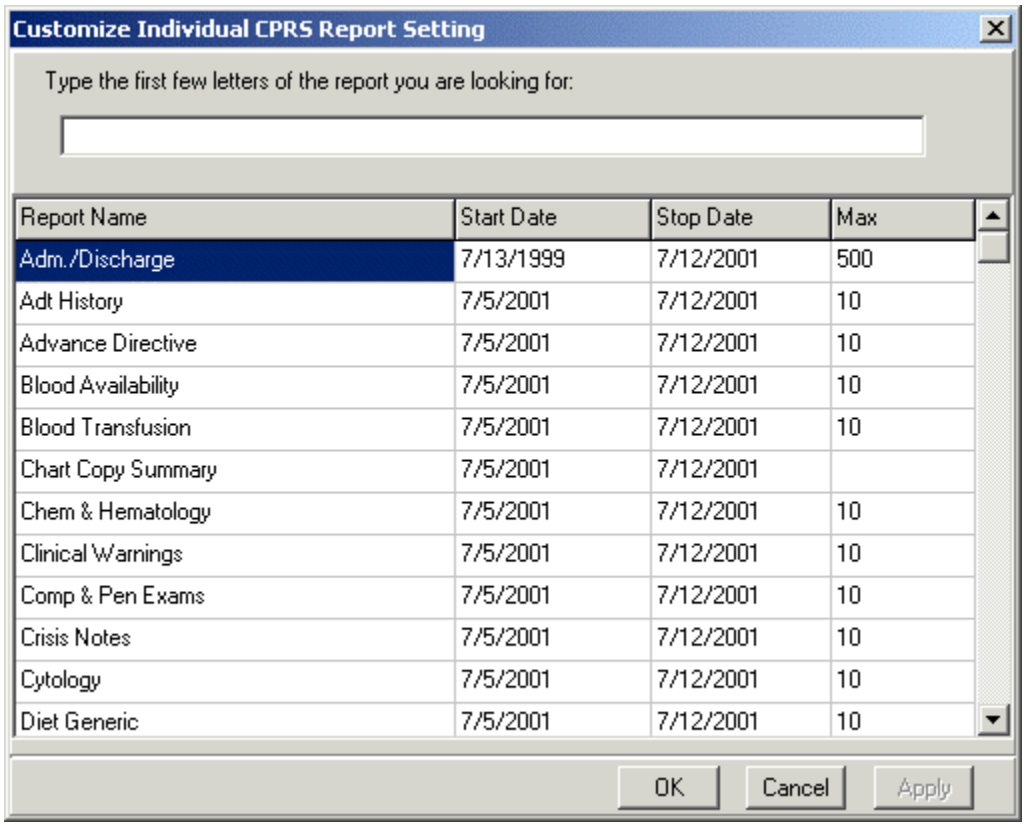


When this dialog appears follow these steps:

1. Change the value in the Start Date and Stop Date fields by clicking in the appropriate field and by doing one of the following:
   a) entering a date (e.g. 6/21/01 or June 21, 2001).
   b) entering a date formula (e.g. t-200).
   c) pressing the ··· button to bring up a calendar.
2. After you have entered a start and stop date, you can change the maximum number of occurrences (if necessary) by clicking in the Max field.
3. Click **OK**.
4. A confirmation dialog box will appear. Click **Yes** to confirm and save your changes.
5. Click **OK** to close the Options dialog box.

Set Individual Report …

This option allows you to set a start date, a stop date, and a maximum number of occurrences for individual CPRS reports. After you press the **Set Individual Report…** button the "Customize Individual CPRS Report Setting" dialog box will appear.



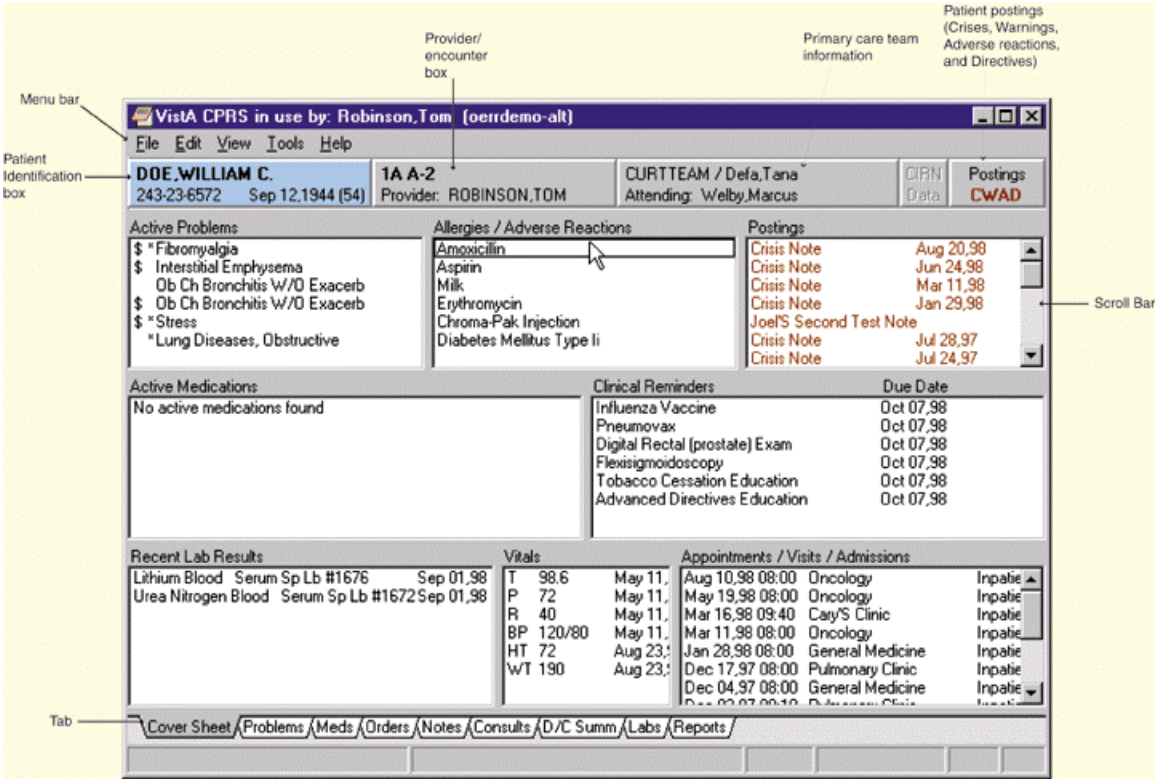
When this dialog appears follow these steps:

1. Place the cursor in the "Type the first few letters of the report you are looking for:" field (located at the top of the dialog box) and type the name of the report that you would like to change
   or
   use the scroll bars to find the report.

2. Change the value in the Start Date and/or Stop Date field by clicking in the appropriate column and doing one of the following:
   a) entering a date (e.g. 6/21/01 or June 21, 2001).
   b) entering a date formula (e.g. t-200).
   c) pressing the ... button to bring up a calendar.
3. After you have entered a start and stop date, you can change the maximum number of occurrences (if necessary) by clicking in the Max field.
4. Click **Apply** to save your changes
   or
   Click **OK** to save your changes and close the dialog box.
5. Click **OK** to close the "Options" dialog box.

Cover Sheet

The Cover Sheet will be the first screen you see after opening a patient record unless your site defines another tab as the initial tab. It presents a quick overview of a patient's condition and history. It shows active problems, allergies and postings, active medications, clinical reminders, lab results, vitals, and a list of appointments or visits.

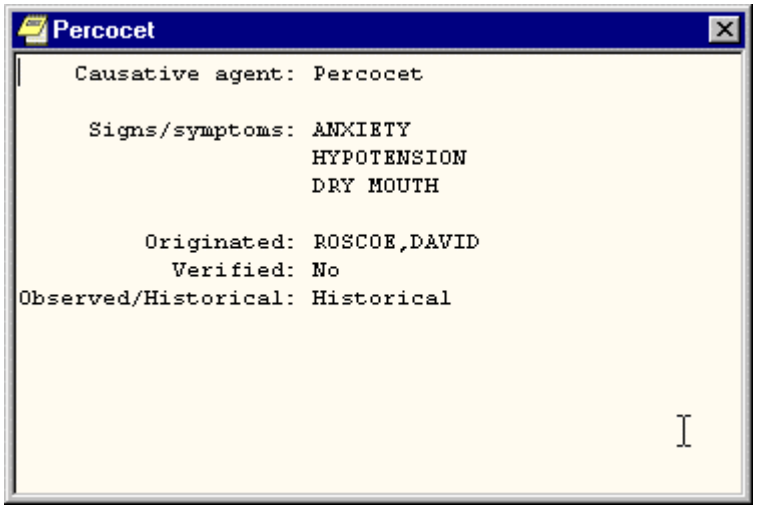


You can quickly review the active problems (asterisks identify acute problems, and dollar signs identify unverified problems). Scroll bars beside a box mean that more information is available if you scroll up or down. Single-click on one of the five menus: File, Edit, View, Tools, or Help, to see choices of things you can do or other options available to you.

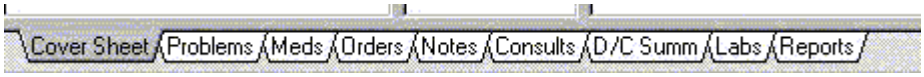
The File menu contains three commands that you will use often:

- **Select New Patient** brings up the Patient Selection dialog.
- **Update/Provider/Location** brings up a dialog that enables you to change the clinician or location of an encounter.
- **Review/Sign Changes** enables you to view the orders you have placed that require an electronic signature, select the orders you want to sign at this time, and enter your electronic signature (if you are authorized to sign them).

Click on any item to get more detailed information. For example, you can click the Patient Identification box (or button) to get more information about the patient. You can click on a Visit to see details. For example, a patient could have Percocet listed in the Allergies/Adverse Reactions dialog. By clicking on it, you would see the following detail window.



Click on a tab at the bottom of the screen to go to that section of the patient chart.



Navigating a Patient Chart

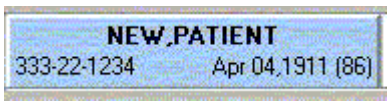
The CPRS Windows interface mimics the paper chart of a patient's record, but CPRS makes locating information easier. With the Patient Selection screen, you can quickly bring up a record for any patient on the system. The Cover Sheet summarizes important information about the patient. Along the bottom of this dialog or page are a number of tabs that will quickly take you to the part of the chart you need to see. For example, you might want to see Progress Notes, Problems, Summaries, Medications, Lab Tests, or place new orders:

To go to a different part of the patient chart, click on the appropriate tab at the bottom of the chart or choose View | Chart Tab, and then select the desired tab.

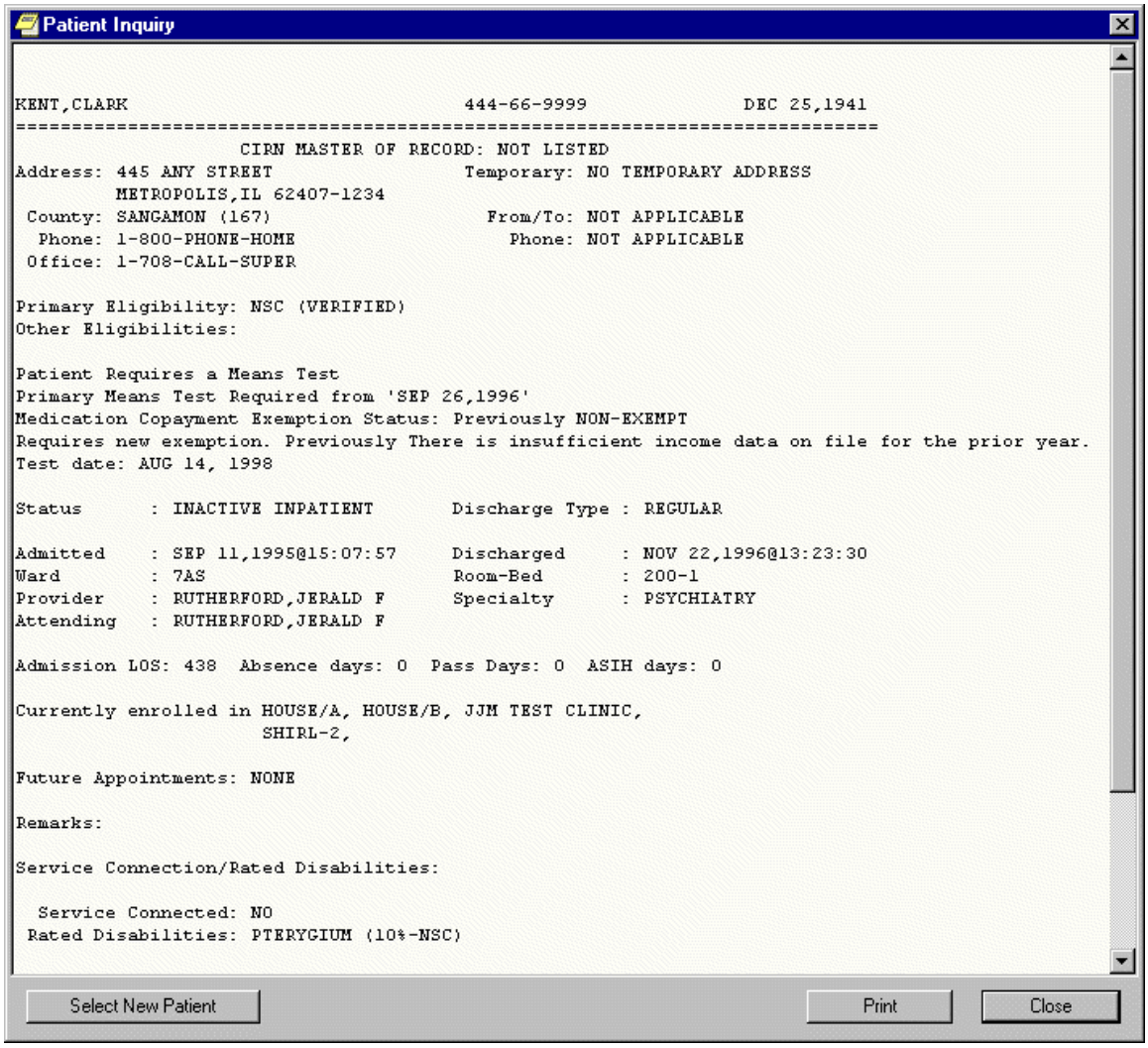
Additional Patient Information

You can obtain additional patient information by clicking the Patient ID box located on the upper left of the dialog. You can access this button from any chart tab.

The button shows the patient's name (in bold), Social Security number, date of birth, and age (as shown in the graphic below). If you click the button, CPRS brings up a window containing additional information such as the patient's address, the attending physician, date of admittance, and so on.



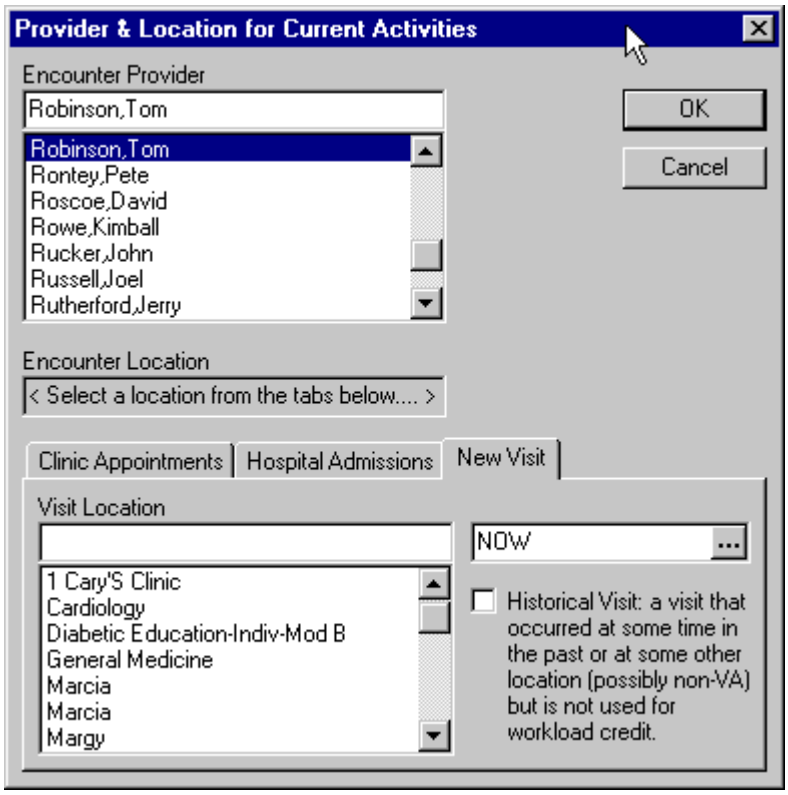
To obtain further information about a patient, click the Patient ID box.



To close the Patient Inquiry window and return to the Cover Sheet, click Close. To select a new patient, click Select New Patient.

Changing Encounter Information

Encounter information is required before you can enter orders, write notes, or other kinds of activities.



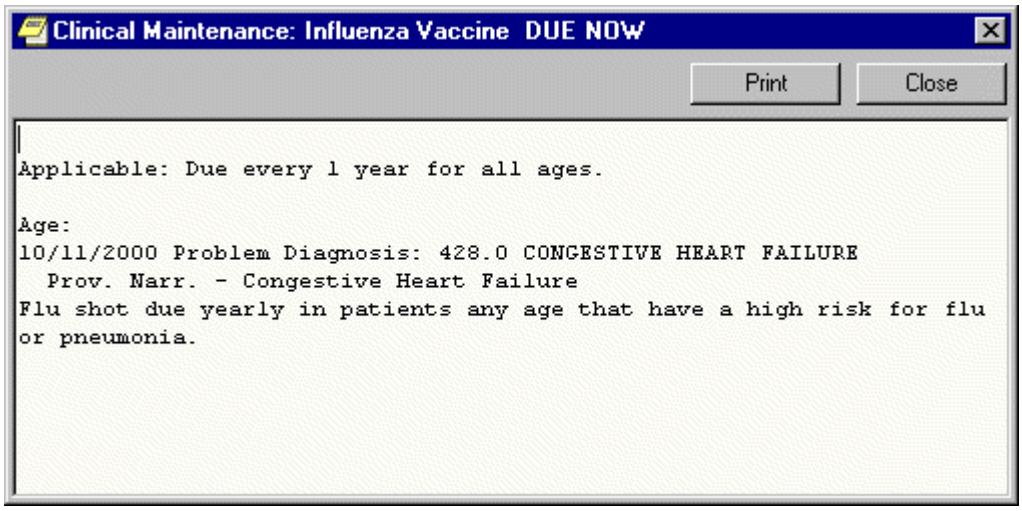
It does not count for workload credit. For that, you must enter encounter form data.

To enter or change the Encounter provider, follow the steps below:

1. If you are already in the Provider / Encounter dialog skip to step 2. Otherwise, from any chart tab, click the Provider / Encounter box located in the top center portion of the dialog.
2. Locate and click the provider for this encounter in the list box.
3. Click the tab of the correct encounter category for this visit:
    - Clinic Appointments
    - Hospital Admissions
    - New Visit
4. Select a location for the visit from the choices in the list box.
5. If you selected a Clinic Appointment or Hospital Admission, skip to step 7. If you are creating a New Visit, enter the date and time of the visit (the default is NOW).
6. Click a visit category from the available options (such as, Historical) and click OK.
7. When you have the correct provider and location, click **OK**.

Viewing Clinical Reminders

From the Cover Sheet, you can double-click on any of the Clinical Reminders listed and obtain a description of the reminder and why it applies to the currently selected patients.



To Process Reminders, you must go to the Notes tab.

Viewing Vitals

CPRS displays the patient's most recent Vitals in the Vitals area (in the lower center portion of the Cover Sheet).

To view the selected patient's vitals history, use these steps:

1. Click on a value in the Cover Sheet's Vitals area. The Vitals dialog appears.
2. In the dialog's upper left, click the time period you want to view (Today, All Results, Date Range, etc.).
3. Click the vital category you want to view (Temperature, Pulse, Respiration, Blood Pressure, Height, Weight, or Pain).
4. Adjust the graph features as desired:

Click Zoom and then enlarge a part of the graph by clicking and dragging from above and left of the area to below and to the right of it.

Click 3D to make the graph into a simple three-dimensional representation.

Click Values to show the numerical value of each graph point.

Reviewing Postings

Postings are a special type of Progress Notes. They contain critical information about a patient that hospital staff need to be aware of. The Postings button is visible on all tabs of the patient chart. It is located in the upper right corner of the dialog.

You can access the full text of a posting through the Postings button from any tab, or from the Cover Sheet, you can select a posting from the Adverse Reaction/Allergies area or the Postings area.

To create a new posting, you simply write a new progress note, and in the Progress Note Title drop-down list, select one of the following:

- Adverse Reaction/Allergy
- Clinical Warning (which is the same as Warning)
- Crisis Note
- Directive
- Warning

Notifications and Alerts

Notifications are messages that provide information or prompt you to act on a clinical event. Clinical events, such as a critical lab value or a change in orders trigger a notification to be sent to all recipients identified by the triggering package (Lab, CPRS, Radiology, and so on).

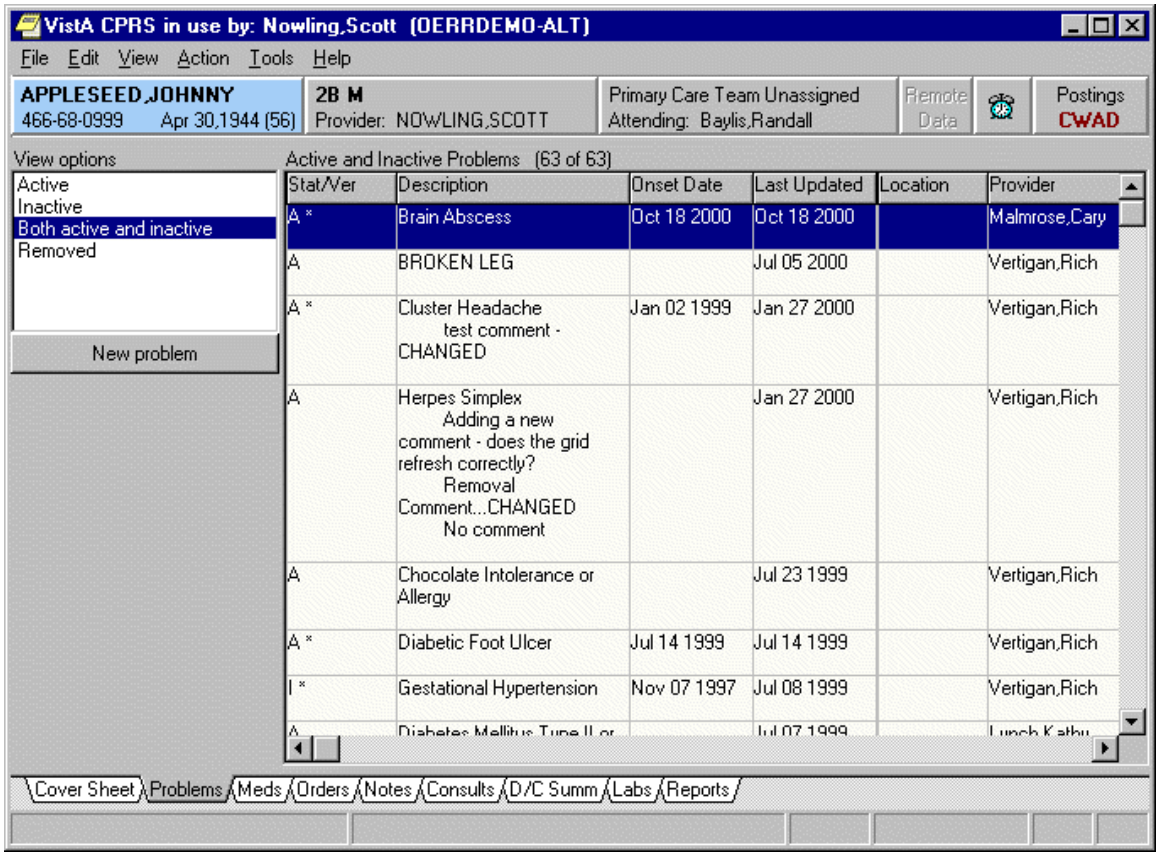
CPRS places an "I" before information notifications. Once you view (process) information notifications, CPRS deletes them. When you process notifications that require an action, such as signing an order, CPRS brings up the chart tab and the specific item (such as a note requiring a signature) that you need to see.

> **Note**: When CPRS is installed, all notifications are disabled. IRM staff and clinical coordinators set site parameters through the Notifications Management Menus in the List Manager version of CPRS that enable specific notifications. Notifications are initially sent to all users. Users can then disable unwanted notifications through List Manager's Personal Preferences.

Clinical Notifications are displayed on the bottom of the Patient Selection screen when you log in to CPRS. Only notifications for your patients are shown.

Problem List

The Problem List documents a patient's problems. It provides clinicians with a current and historical view of the patient's health care problems across clinical specialties. It allows each identified problem to be traceable through the VISTA system in terms of treatment, test results, and outcome.



You have a choice of how to display a patient's problems: active problems only, inactive problems only, both active and inactive problems, and problems for a selected service or provider by customizing your view of the problem list.

You can change the view, add, deactivate, remove, verify, or annotate problems.

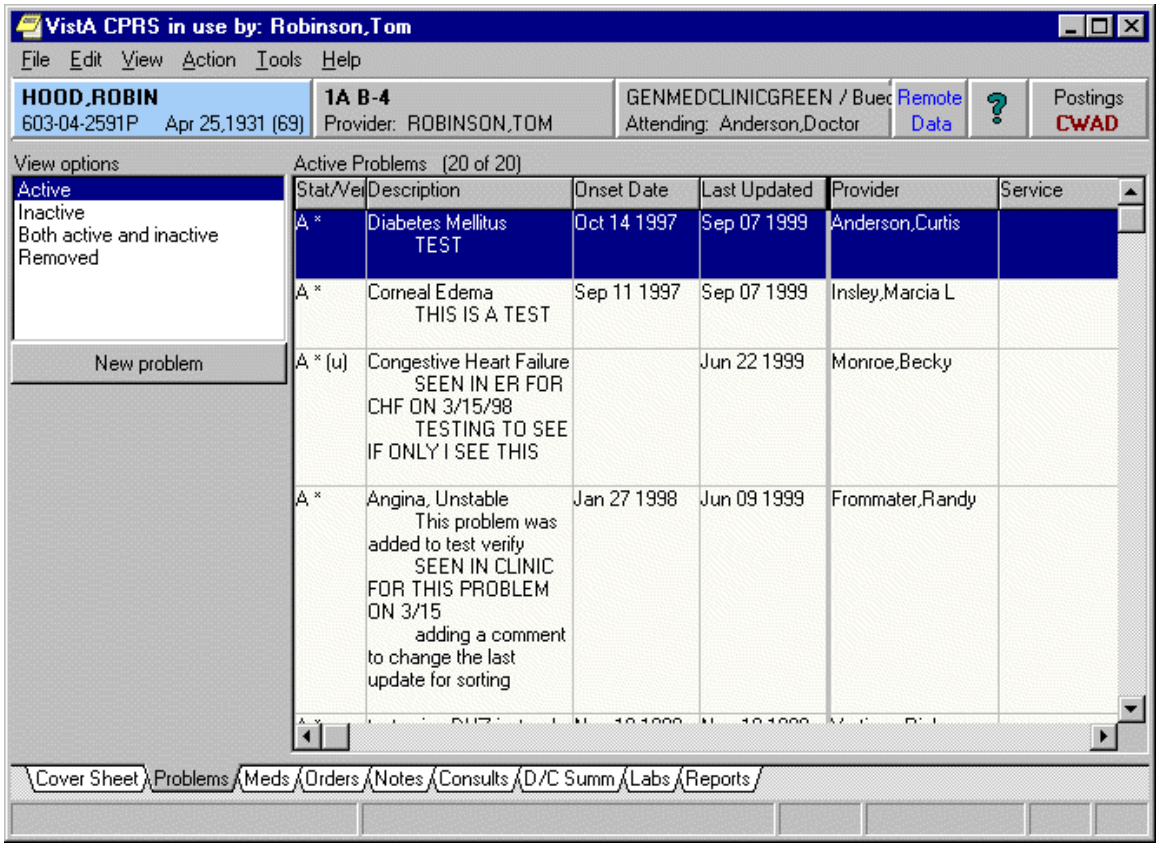
When "Removed" problems are viewed, the "Stat/Ver" column is hidden to minimize user confusion about the status of "Removed" problems.

Changing Views on the Problem List

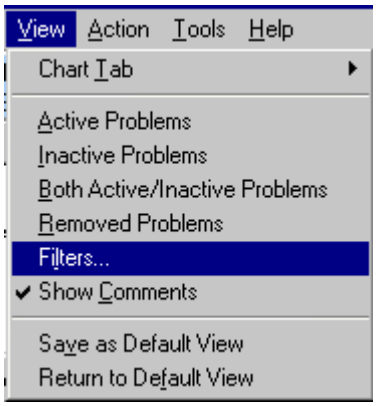
Changing the view of the Problem List allows you to focus the list of problems on one of several criteria. Focusing the list will speed up the selection process.

You may change the Problems List view to only include the following problems:

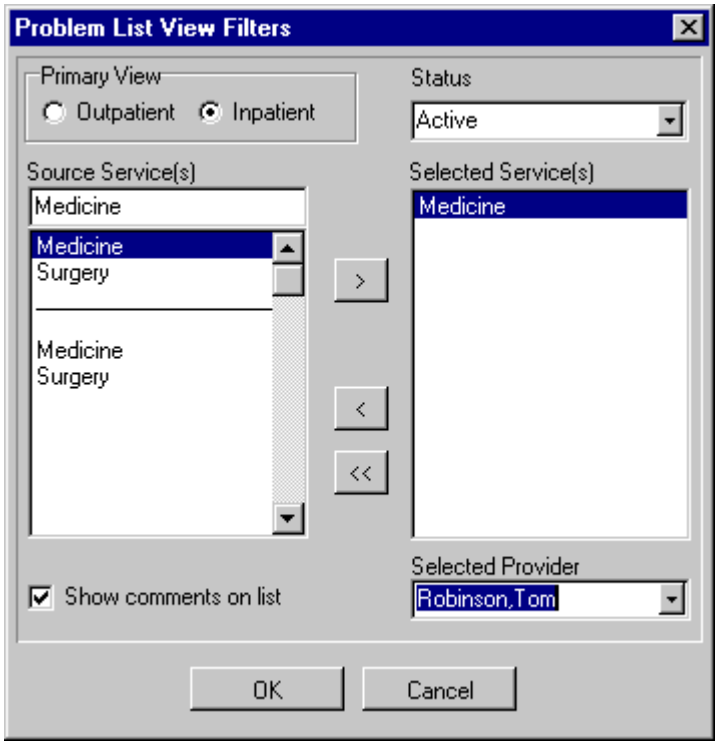
- Active
- Inactive
- Active and Inactive
- Removed



To change the view, click on any of the options listed in the View options field or click on View on the menu.

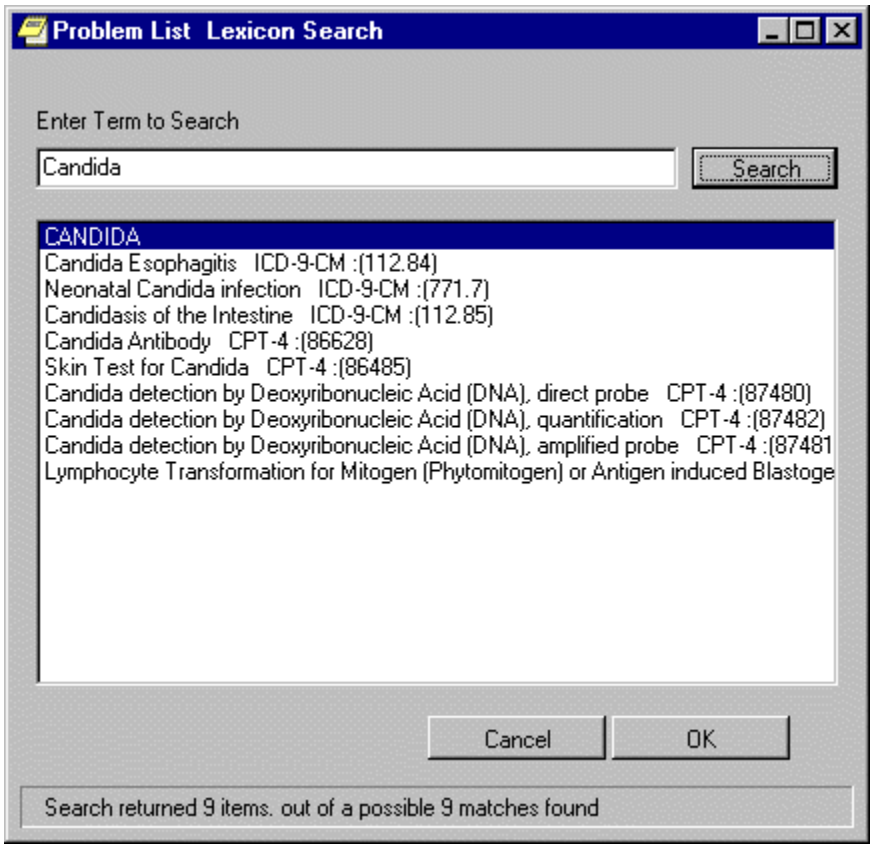


You may select the Filters… option on the menu to further focus the list of problems you wish to have displayed. From the Filters dialog, you may choose to display problems by any combination of Status, Source Clinic (which is listed when you select Outpatient), Source Service (which is listed when you select Inpatient), and Provider.



Adding a Problem

You add a new problem from the Problems tab. From this tab, you can add, remove, change, verify, and annotate a problem.



To add a new problem to a patient's problem list, use these steps:

1. Click the **Problems** tab.
2. Click **New Problem**.

   Note: If you have not defined the provider or location, you will be prompted for this encounter information.
3. Select a problem from the list or search the lexicon for the problem by clicking **Other Problem** on the lower left side of the Problems tab, entering terms that describe the problem in the Problem List Lexicon Search field, and then pressing **Enter** or click **Search**. When the list appears, locate and click on the problem.
4. Enter information about the problem, such as whether it is acute or chronic, treatment factors (Service Connected, Radiation, Agent Orange, or Environmental Contaminants), the Date of Onset, the provider, and the clinic.
5. Add a comment if you wish by clicking **Add Comment** and entering the comment in the dialog that appears. Then click **OK**.
6. Click **OK** again.

Annotating a Problem

To annotate a problem, use these steps:

1. Click on the **problem** in the problem list.
2. Select **Action | Annotate...** or right-click the problem and select **Annotate...** from the pop-up menu.
3. Enter your annotation in the dialog that appears (up to 60 characters).
4. Click **OK**.

Changing a Problem

To change a problem on a patient's problem list, use these steps:

1. Click the **Problems** tab.
2. Click on the problem in the list box that you want to change.
3. Select **Action | Change**.
4. Enter the desired changes.
5. Add or remove a comment if desired.

   Note: A comment can be as many as 60 characters (including spaces) in length.
6. Click **OK**.

   Note: When you view the details of a problem, you will see who changed the problem and when.

Deactivating a Problem

To deactivate a problem on a patient's problem list, use the following steps:

1. Click on a problem in the list box.
2. Select **Action | Inactivate.**

Removing a Problem

A problem is not removed from the database because things "pointing" to it might be broken if it is removed. A field in the problem record can be "flagged" with an "H" and the problem will be HIDDEN. Any software that runs on the database must look at the field to see if it is hidden or not. The hidden record will not appear on any reports or lists and will appear to the user that it has been removed. Actually it is only removed from sight.

To remove a problem from a patient's problem list, use these steps:

1. Click on the problem.
2. Select **Action | Remove** or right-click the problem and click Remove.

Verifying a Problem

To verify a problem on a patient's problem list, use these steps:

1. Click on the problem in the problem list.
2. Select **Action | Verify** or right-click the problem and click **Verify** on the pop up menu.

Customizing the Problem List

On the Problems tab, you can sort the problem list by problem status or use the view filtering to get a more specific list of problems. You can sort the list to see the following:

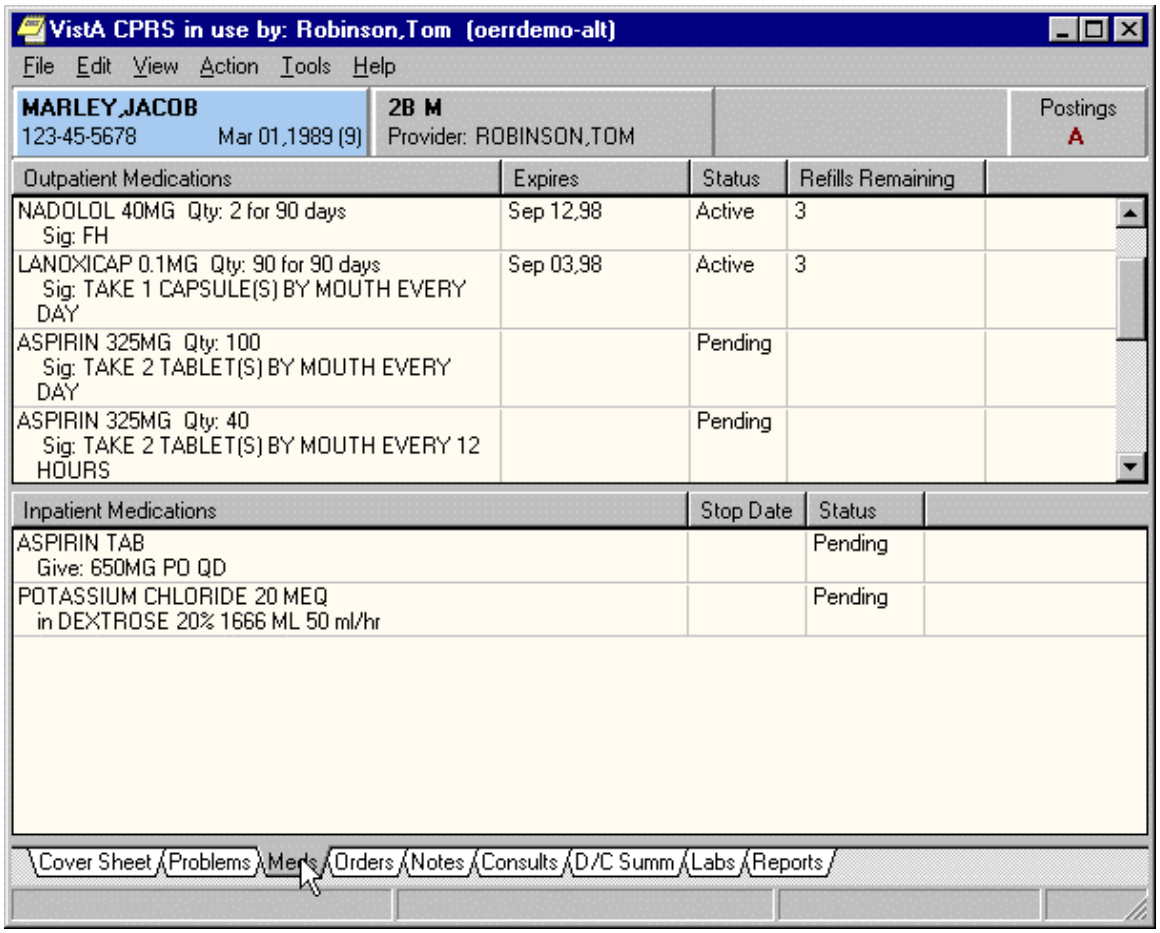
- Active Problems
- Inactive Problems
- Both Active/Inactive Problems
- Removed Problems

Meds

The Meds tab is a listing of medications for the selected patient. Inpatient and Outpatient Medications are listed in different areas. You can see in the graphic below the information that CPRS presents for each medication. Depending on your needs, the Outpatient Medications field can be enlarged or reduced in size by holding the cursor near the bottom edge of the field until it turns into a double-line with up and down arrow heads. Click and drag the field to the size you desire.

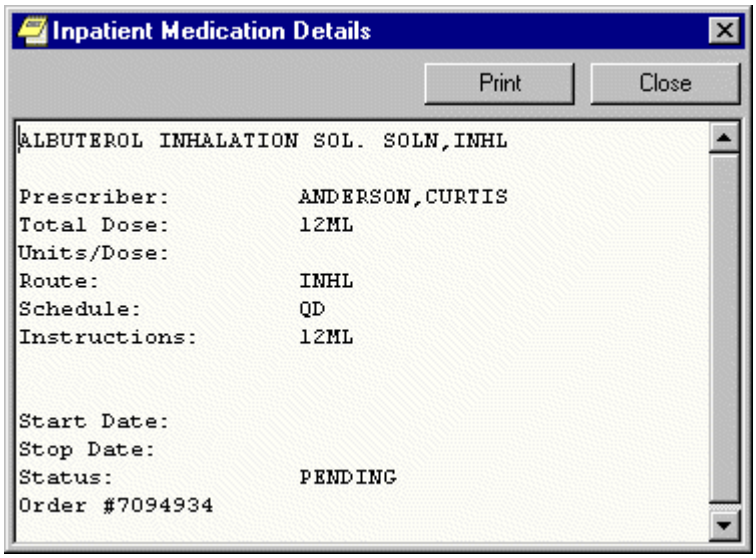
To get additional details on a specific medication order, double-click the entry or select **View | Details**. To take other actions, ordering a new medication, changing a medication order, or changing a medication order status (discontinue, hold, or renew), you use the Action menu or right-click on a medication.

You can also place orders for new medications from the Orders tab.



Changing Views on the Meds tab

Changing view on the Meds tab simply reformats the information for a particular medication so that it can be printed or viewed. You may double-click on any medication either the Outpatient of Inpatient lists or you may highlight any medication and click on View | Details.



Inpatient Meds

Ordering medications now uses two dialogs in the ordering process and eliminates the dispense drug prompt.

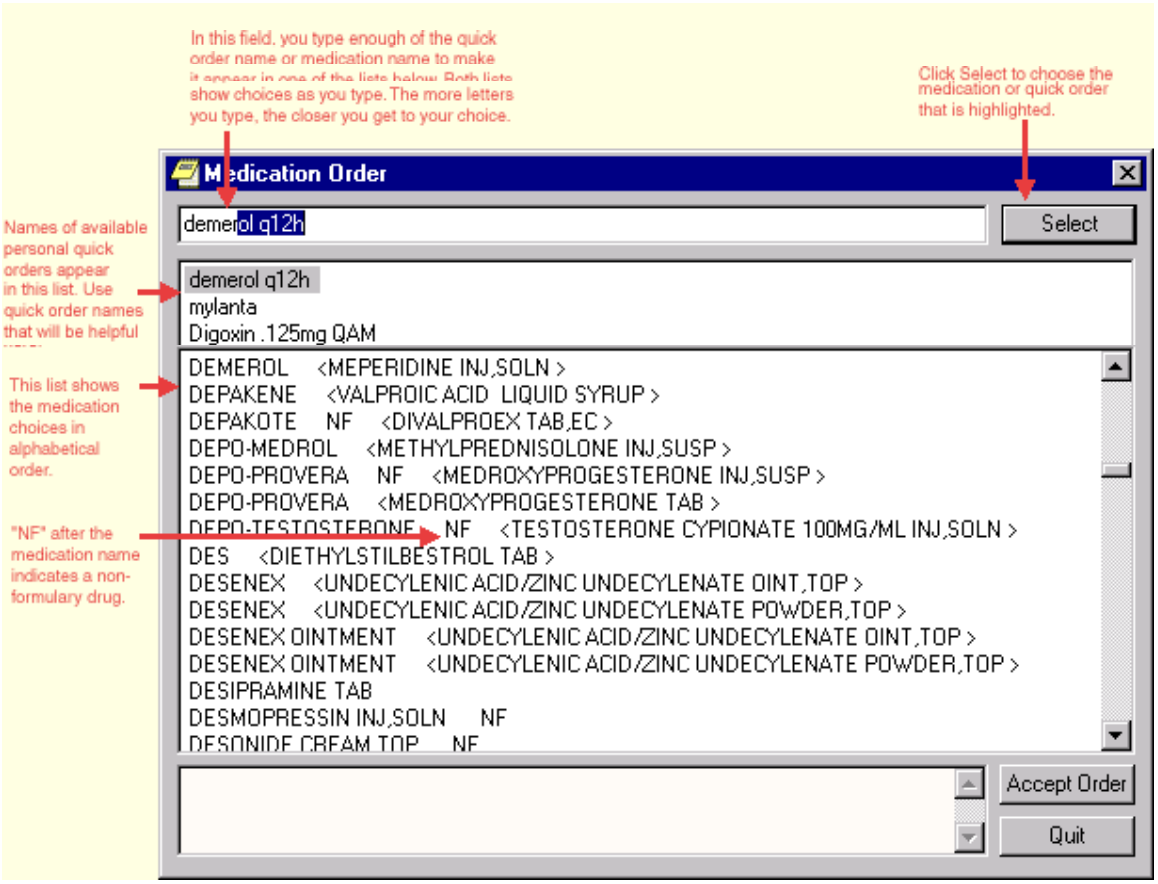
Simple Dose

To write a new simple dose Inpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

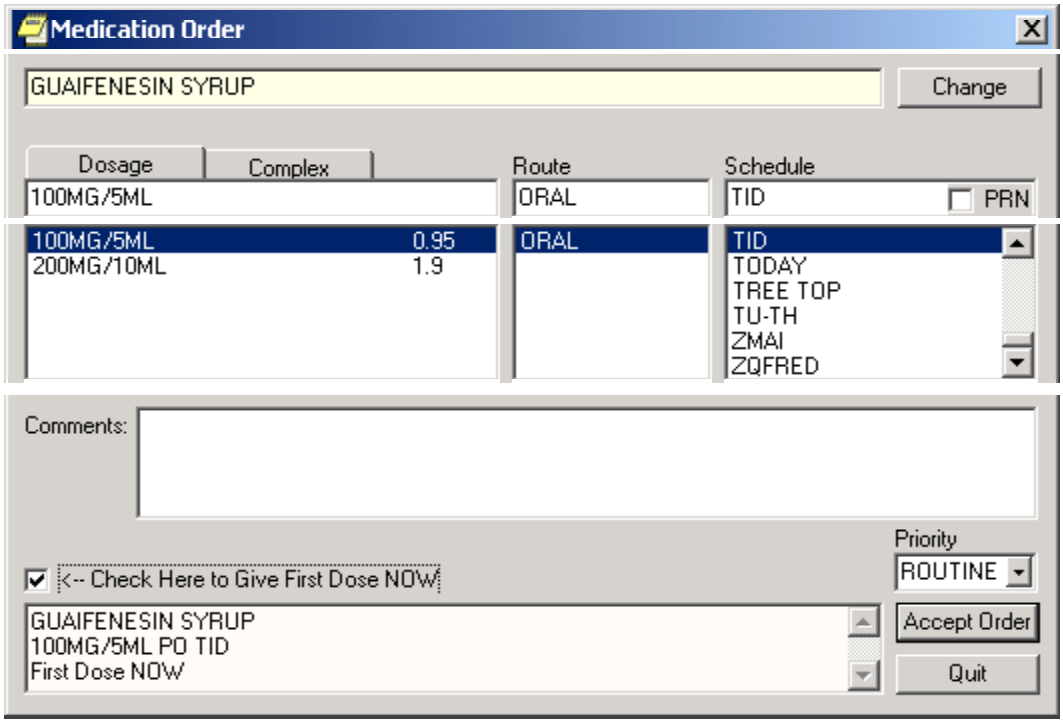
   Click the **Orders** tab and bring up the Inpatient dialog by clicking the appropriate item under the Write Orders box. CPRS will display the Medication Order dialog as show in the graphic below.



2. Locate the desired medication or medication quick order. Click the quick order or medication name.

Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

3. Click the dosage field and select a dosage. (The associated cost is displayed to the right of the dosage.)



4. Select values for the Route and Schedule fields and click PRN if desired.
5. Add comments, if desired.
6. CPRS displays when the first dose of the medication is expected to be given. If you want to give the first dose now, click to place a check in the "Give First Dose Now" check box.

Note: Make sure that you are careful about using "Give First Dose Now". When you click the check box, a new order is created and sent to Inpatient Medications. Check to make sure the Now order and the original schedule you entered do not overmedicate the patient.

7. Click the drop-down arrow and select a Priority.

8. Click **Accept Order**.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you that the information is incorrect and shows you the correct type of response.

9. Enter another medication order or click **Quit**.

Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Complex Dose

To write a new complex dose Inpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

   Click the **Orders** tab and bring up the Inpatient dialog by clicking the appropriate item under the Write Orders box.

2. Locate the desired medication or medication quick order. Click the quick order or medication name.

Note: CPRS now uses an look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

3. Click the **Complex** dose tab.

Note: Once you begin a complex order, you must remain on the Complex tab until you finish that order. Do not attempt to start from or switch back to the Dosage tab. If you do, all complex dosages will be erased and you will be forced to start again.

4. Click the dosage field and select the appropriate dosage.
5. Click the Route cell and enter the route (The default route should be the most common).
6. Click the Schedule cell and enter how often the medication should be taken (click PRN if desired).
7. Click the Duration cell and enter a number and select units (days is the default) a patient should use the specified dose.
8. Add the appropriate conjunction: And, Then, Except (Except is only for Outpatient Meds) or no conjunction for the final line.
9. Click in the dosage field in the next row and select a dosage.
10. CPRS will fill in the Route and Schedule fields. If necessary, click in and change the Route and Schedule cells.
11. Click and enter a duration and a conjunction.
12. Repeat steps 10-12 until you have completed the complex dose.

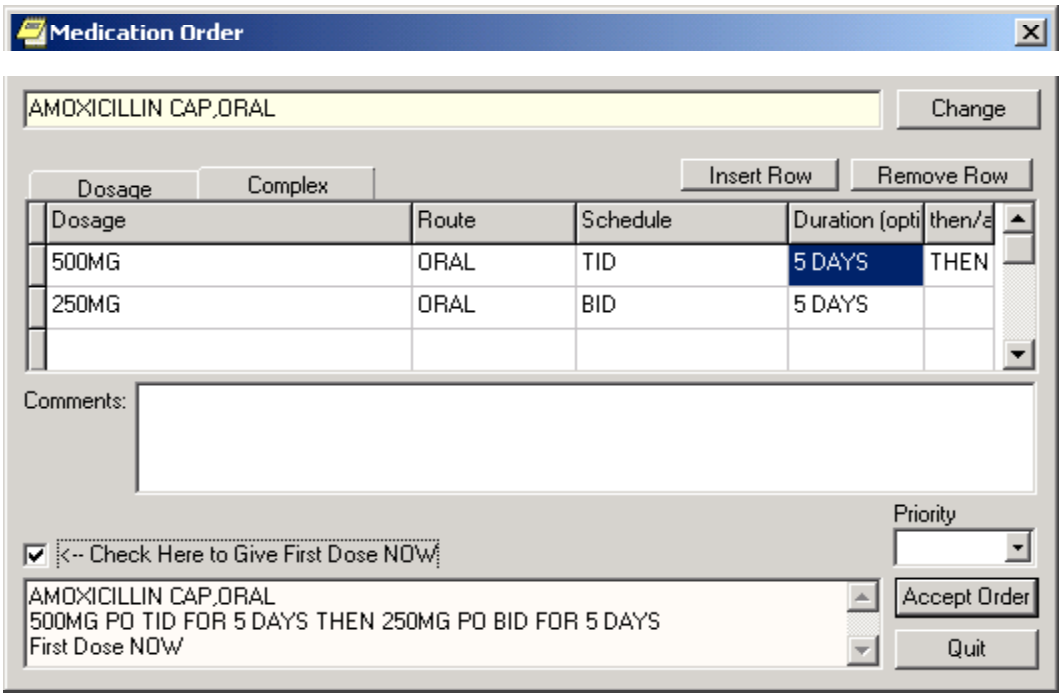
Note: You can also add or remove a row in the complex dosage. If you add a row, the new row will be placed above the selected row. To add a row, click the gray area in front of the row and click **Add Row**. To delete a row, click the gray area in front of the row to be deleted and click **Delete Row**.

13. Add comments, if desired.

14. CPRS displays when the first dose of the medication is expected to be given. If you want to give the first dose now, click to place a check in the " Give First Dose Now" check box.

Note: Make sure that you are careful about using “Give First Dose Now”. When you click the check box, a new order is created and sent to Inpatient Medications. Check to make sure the Now order and the original schedule you entered do not overmedicate the patient. If the provider checks “Give First Dose Now”, CPRS displays the following message: “First Dose Now is in addition to those listed in the table. Please adjust the duration of the first row, if necessary” as shown in the graphic below.

15. Click the drop-down arrow and select a Priority.



16. Click **Accept Order**.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you that the information is incorrect and shows you the correct type of response.

17. Enter another medication order or click **Quit**.

Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Outpatient Meds

Outpatient meds can be written as simple doses or complex doses. To write a new Outpatient Medications order, use these steps:

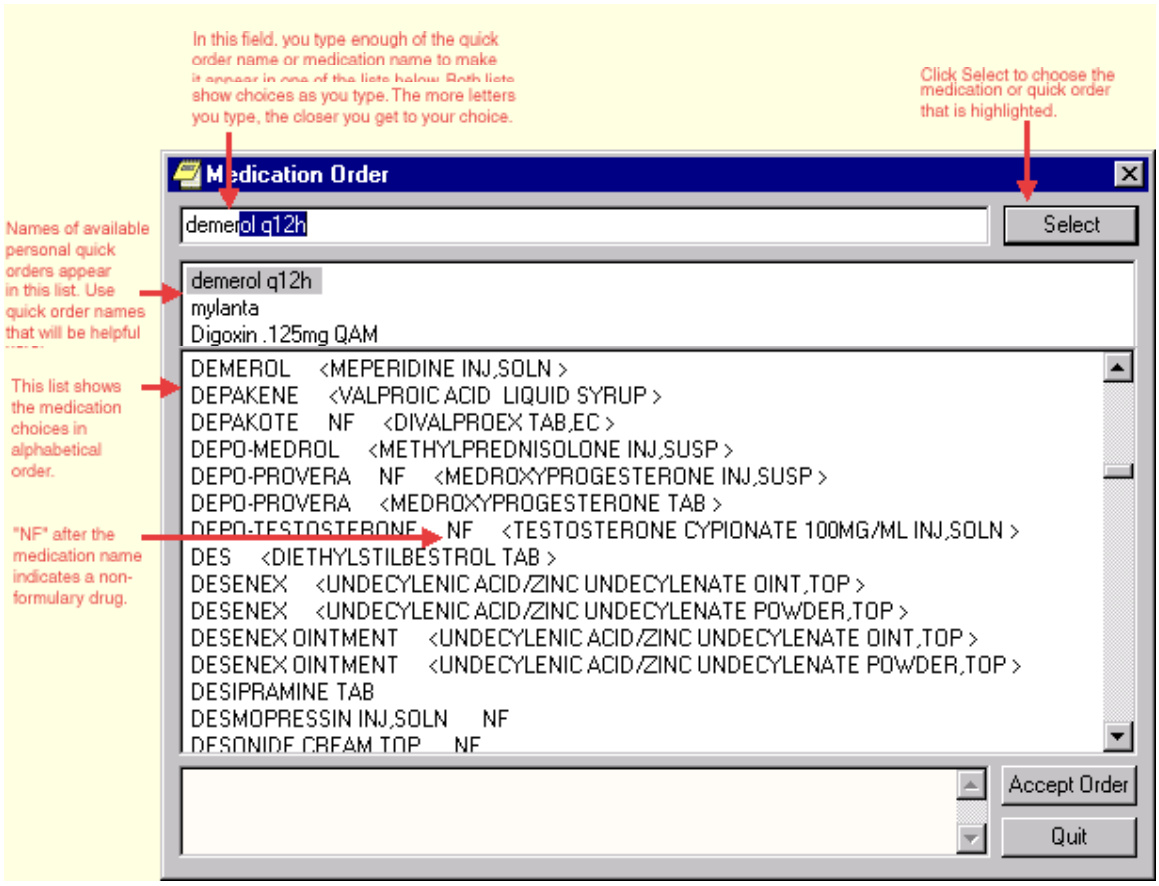
Simple Dose

To write a new simple dose Outpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

   Click the **Orders** tab and bring up the Outpatient dialog by clicking the appropriate item under the Write Orders box. CPRS will display the Medication Order dialog as shown in the graphic below.



Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

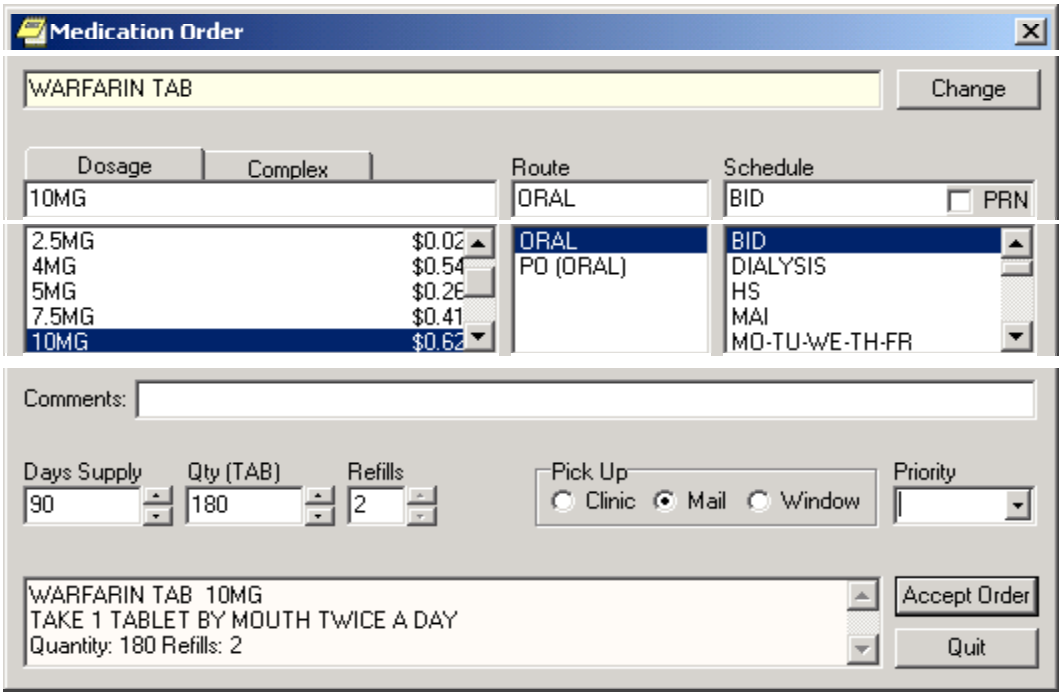
2. Locate the medication name or quick order name in the list box and then click it.

Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

3. Select the dosage. (The associated cost is displayed to the right of the dosage, see graphic under step 9 for an example.)
4. Select values for the Route and Schedule fields (select PRN, if desired).
5. CPRS puts in the default days supply and calculates the quantity based on the formula Days Supply x Schedule = Quantity. If necessary, highlight and change the numbers in these fields.

Note: If you change a number, CPRS will attempt to recalculate the other field, if possible.

6. Enter the number of refills.
7. Select where the patient should pick up the medication and the Priority.
8. You can also add a comment if desired.
9. Under certain circumstances, a check box may appear under the Days Supply field. If the medication is service-connected, make sure the box is checked.



10. Click **Accept Order**.

11. If you are finished ordering outpatient medications, click **Quit**.

Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Complex Dose

To write a new Outpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

   Click the **Orders** tab and bring up the Outpatient dialog by clicking the appropriate item under the Write Orders box.

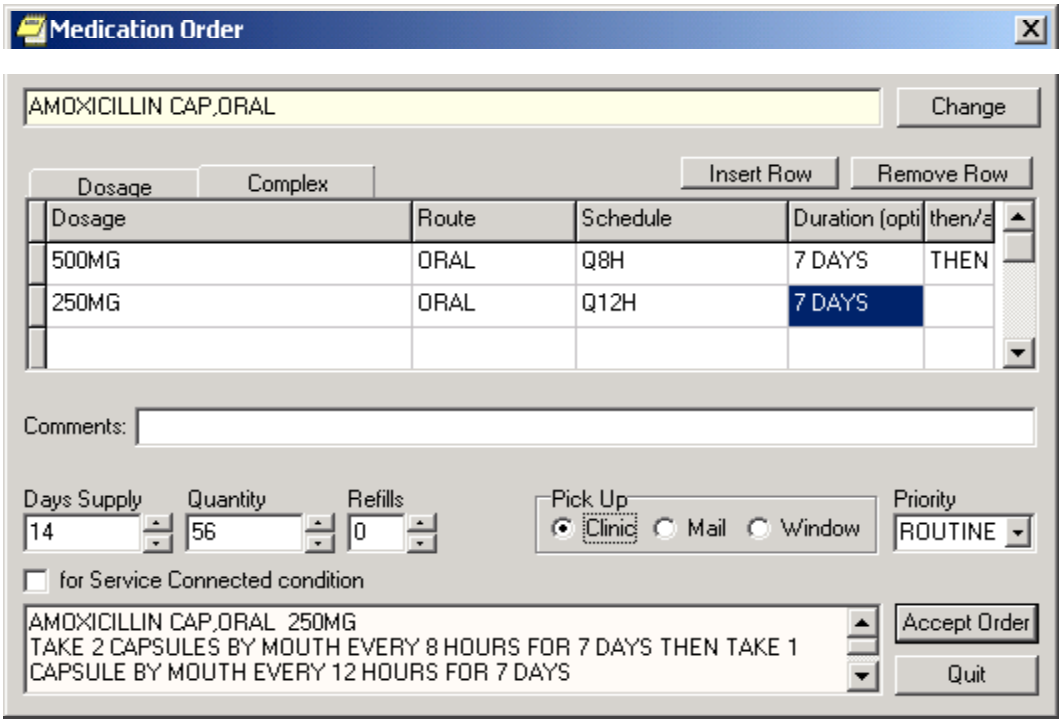
Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

2. Locate the medication name or quick order name in the list box and then click it.

Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

3. Click the **Complex** dose tab.

Note: Once you begin a complex order, you must remain on the Complex tab until you finish that order. Do not attempt to start from or switch back to the Dosage tab. If you do, all complex dosages will be erased and you will be forced to start again.



4. Click the dosage field and select the appropriate dosage.
5. Click the Route cell and enter the route (The default route should be the most common).
6. Click the Schedule cell and enter how often the medication should be taken (click PRN if desired).
7. Click the Duration cell and enter a number and select units (days is the default) a patient should use the specified dose.
8. Add the appropriate conjunction: And, Then, Except (Except is only for Outpatient Meds) or no conjunction for the final line.
9. Click in the dosage field in the next row and select a dosage.
10. CPRS will fill in the Route and Schedule fields. If necessary, click in and change the Route and Schedule cells.
11. Click and enter a duration and a conjunction.
12. Repeat steps 10-12 until you have completed the complex dose.

Note: You can also add or remove a row in the complex dosage. If you add a row, the new row will be placed above the selected row. To add a row, click the gray area in front of the row and click **Add Row**. To delete a row, click the gray area in front of the row to be deleted and click **Delete Row**.

13. CPRS puts in the default days supply and calculates the quantity based on the Days Supply x Schedule = Quantity. If necessary, highlight and change the number in these fields.

Note: If you change a number, CPRS will attempt to recalculate the other field, if possible.

14. Enter the number of refills.
15. Select where the patient should pick up the medication and the Priority.
16. You can also add a comment if desired.
17. Under certain circumstances, a check box may appear under the Days Supply field. If the medication is service-connected, make sure the box is checked.
18. Click **Accept Order**.
19. If you are finished ordering outpatient medications, click **Quit**.

Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Hold Orders

Only active orders may be placed on hold. Orders placed on hold will continue to show under the ACTIVE heading on the profiles until it is removed from hold. An entry is placed in the order's Activity Log recording the person who placed/removed the order from hold and when the action was taken.

To place a medication on hold, use these steps:

1. Click the **Meds** tab.
2. Locate and click the medication.
3. Select **Action | Hold**.

Renewing Orders

Active orders may be renewed. In addition, inpatient medication orders that have expired in the last four days and outpatients medication orders that have expired in the last 120 days may be renewed. The default Start Date/Time for a renewal order is determined as follows:

Default Start Date Calculation = NOW

The default start date/time for the renewal order will be the order's Login Date/time.

Default Start Date Calculation = USE NEXT ADMIN TIME

The original order's Start Date/Time, the new order's Login Date/Time, Schedule, and Administration Times are used to find the next date/time the order is to be administered after the new order's Login Date/Time. If the schedule contains "PRN" any administration times for the order are ignored.

Default Start Date Calculation = USE CLOSEST ADMIN TIME

The original order's Start Date/Time, the new order's Login Date/Time, Schedule, and Administration Times are used to find the closest date/time the order is to be administered after the new order's Login Date/Time. If the schedule contains "PRN" any administration times for the order are ignored.

After the new (renewal) order is accepted, the Start Date/Time for the new order becomes the Stop Date/Time for the original (renewed) order. The original order's status is changed to RENEWED. The renewal and renewed orders are linked and may be viewed using the History Log function. Once an order has been renewed it may not be renewed again or edited.

Discontinuing Orders

When an order is discontinued, the order's Stop Date/Time is changed to the date/time the action is taken. An entry is placed in the order's Activity Log recording who discontinued the order and when the action was taken. Pending and Non-verified orders are deleted when discontinued and will no longer appear on the patient's profile.

To discontinue an order, use these steps:

1. Click the **Orders** tab.
2. Click the order you want to discontinue.
3. Select **Action | Discontinue/Cancel.** A dialog may appear asking for the clinician's name and the location (encounter information).
4. Click the name of the clinician (you may need to scroll through the list), click the encounter location, and then click **OK**. Another dialog will appear asking for the reason why the order is being discontinued.
5. Select the appropriate reason from the box in the lower left of the dialog and click **OK**.

Changing Orders

To change a Medication order:

1. Click either the **Meds** tab or the **Orders** tab.
2. Click the medication order to select it.
3. Select **Action | Change...** or right-click the order and click **Change....**

   Note: If the provider or location has not been defined, you will be prompted for that information.
4. Complete the changes as appropriate in the dialog box that appears on the screen.
5. Click **Accept**.
6. You may sign the order now or later.

Placing a Medication Order

To write a new Inpatient Medications order, use these steps:

1. From the Meds tab, select **Action | New Medication**.

   From the Orders tab, click Meds, and then select Inpatient in the Write Orders box.

   Note: If no encounter information has been entered, the Encounter Information dialog appears. A preliminary order check is done and a dialog may appear to provide you with pertinent information.
2. Locate and click on the desired medication in the Medication list box.
3. Locate and click the drug to be dispensed from the Dispense Drug list.

   Note: For order checking to work correctly, you must enter the dispense drug.

4. Enter or select Dosage, Route, Schedule, and Priority from the boxes of the ordering dialog that appears.

   Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you that the information is incorrect and shows you the correct type of response.

5. Add comments, if desired.
6. Click **Accept Order**.
7. Enter another medication order or click **Quit**.

   Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Viewing a Meds Order

When you select the Meds tab, you see a list of medications that have been ordered for this patient. You can get a more detailed display of each order by double-clicking the order.

Note: You can also review or add medication orders from the Orders tab.

When ordering medications, you can order Outpatient Pharmacy or Inpatient Meds, which includes IV Fluids and Unit Dose.

Transfer Outpatient Meds Order to Inpatient

You can transfer outpatient medications to inpatient medications with CPRS. CPRS will tell you if the medication cannot be changed to an inpatient medication.

Because of the differences, you will go through each order and make the necessary changes.

To transfer the medication to inpatient, use these steps:

1. Click the **Meds** tab.
2. Select the outpatient medications you want to transfer. Hold down the CTRL key to select more than one medication. Hold down the SHIFT key and click on the first and last medications to select a range.
3. Select **Action | Transfer to Inpatient**.
4. Enter the necessary information for the first order and click Accept.
5. Repeat step 4 as needed for the selected medications.
6. When finished, you can sign the orders now or wait until later.

Transfer Inpatient Meds Order to Outpatient

You can transfer inpatient medications to outpatient medications with CPRS. CPRS will tell you if the medication cannot be changed to an outpatient medication.

Because of the differences, you will go through each order and make the necessary changes.

To transfer the medication to outpatient, use these steps:

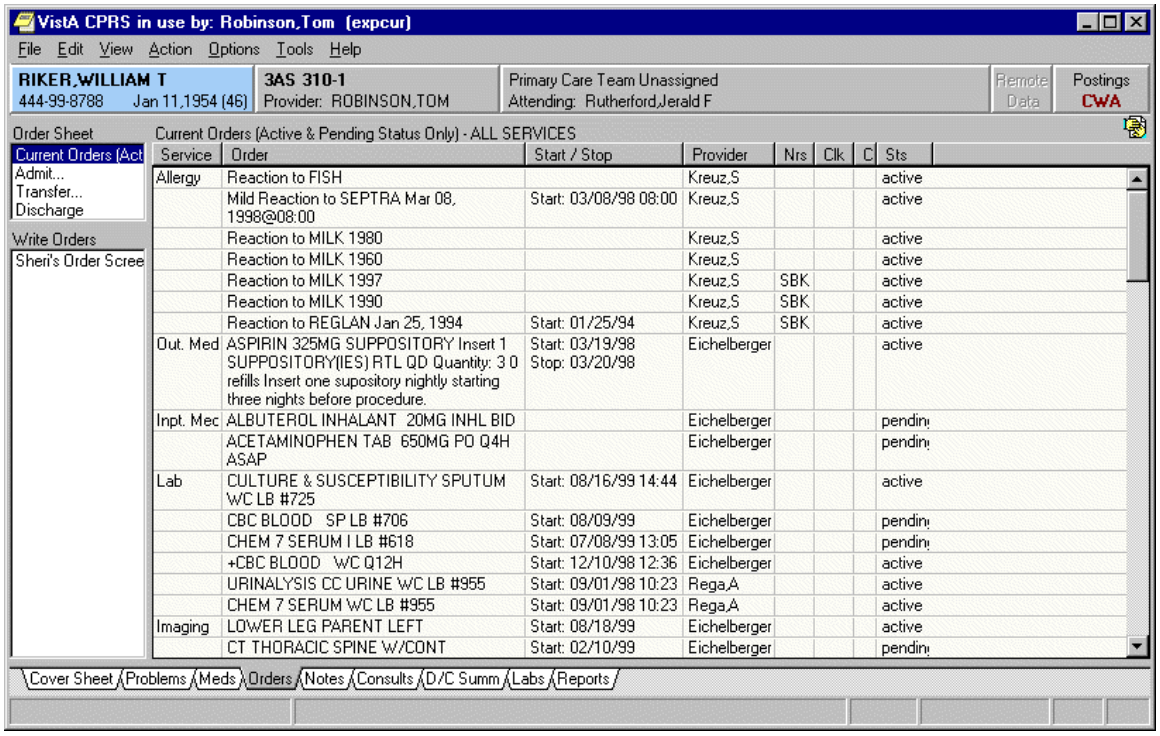
1. Click the **Meds** tab.
2. Select the inpatient medications you want to transfer. Hold down the CTRL key to select more than one medication. Hold down the SHIFT key and click on the first and last medications to select a range.
3. Select **Action | Transfer to Outpatient**.
4. Enter the necessary information for the first order and click **Accept**.
5. Repeat Step 4 as needed for the selected medications.
6. When finished, you can sign the orders now or wait until later.

Orders

On the Orders tab, you can write new orders and view existing orders for the selected patient. CPRS lets you choose from the following methods of sorting the orders that are displayed:

- Active Orders (includes pending and recent activity)
- Current Orders (includes active and pending)
- Expiring Orders
- Unsigned Orders
- Custom Order List...

All of these options are under the View menu. If you choose one of the first four options, CPRS immediately sorts the list to show the orders in that category. If you choose Custom Order List..., you can make the list of orders very specific. For example, you can view orders from a selected service only. When the Orders tab is displaying only some of the orders, an icon appears below the Postings button on the right side of the dialog. The icon is of a pair of hands covering a sheet of paper and indicates that the user is not seeing all of the orders for the selected patient.



You can also save a view as your default order view by clicking on **View | Save As Default View…**.

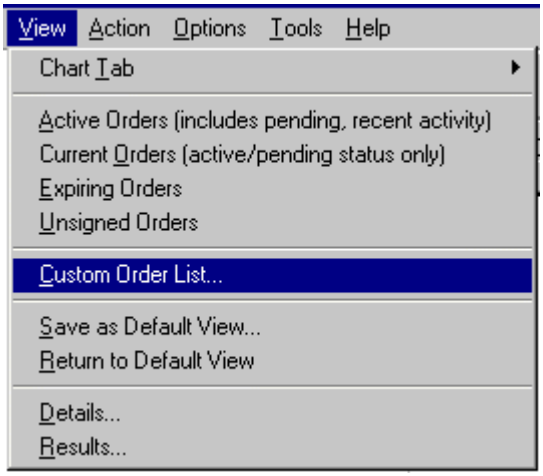
When you view any category of orders, you can quickly get information about each order in the list such as what services the orders are for, the start and stop dates for each order, the name of the provider (or nurse or clerk) that entered the order, and the status of the order.

Changing Views on the Orders tab

Changing the view of the Orders tab allows you to focus the list of orders on one of several criteria. Focusing the list will speed up the selection process.

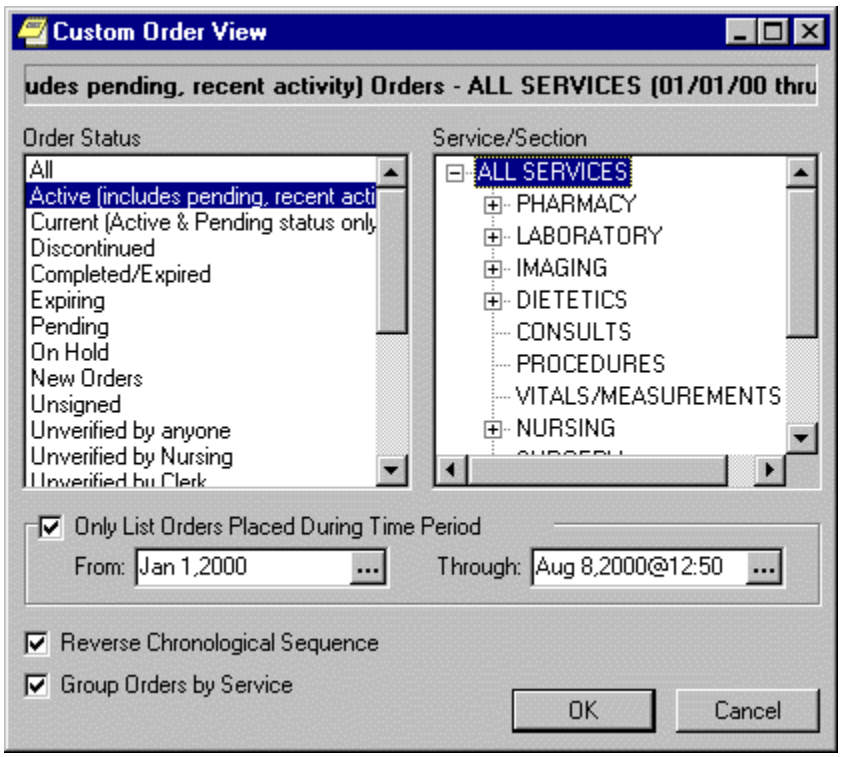
You may change the Orders List view to only include the following problems:

- Active Orders (includes pending and recent activity)
- Current Orders (includes only active and pending orders)
- Expiring Orders
- Unsigned Orders



To change the view, click on the View menu and select the desired list items. You may also double-click on Active Orders in the Orders Sheet field to access that list.

You may select the Custom Order List… option on the menu to further focus the list of orders you wish to have displayed. From the Custom Order View dialog, you may choose to display orders by any combination of Order Status, Service/Section, and date range.



How to Write Orders

With CPRS, you can write orders for medications, consults, lab tests, and so on. You place orders from the orders tab, where you can also view the existing orders.

With CPRS, you can enter orders to be active immediately or enter delayed orders that will become active when the selected patient is admitted, transferred, or discharged. You choose this by selecting the appropriate order sheet (Active, Admit, Transfer, or Discharge) from the Order Sheet field on the upper left corner of the Orders tab.

Once you have selected the appropriate order sheet, you can select an order type from the Write Orders list box, and a new dialog specific to that type of order appears.

CPRS supports Quick Orders and Order Sets. Quick Orders allow the user to enter common or standard orders without going through all of the steps. Quick Orders are set up in advance and then selected a list. Quick Orders are ones that physicians have determined to be their most commonly ordered items and have standard collection times, routes, and other conditions. Order Sets are collections of related orders or Quick Orders, (such as Admission Orders or Pre-Op Orders).

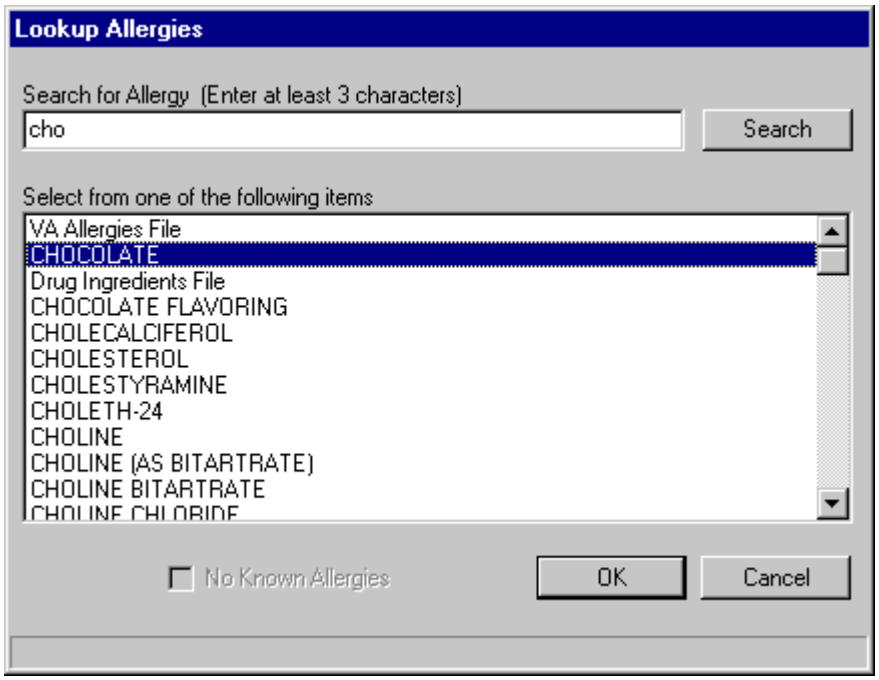
As you specify the order conditions, the order text is displayed in a text field on the ordering dialog, allowing you a way to quickly check your order before you choose Accept Order.

Order checks are performed on all orders when you click Accept Order and before you sign the order to identify duplicate orders, order contraindications, and for other conditions. If the order checks find any of these conditions, you can review them and decide whether to continue placing the order, change it, or cancel it.

Allergies

You can enter allergies when you enter patient orders. After entering one or more allergies, CPRS includes the allergies automatically in its order checks.

To enter an assessment of "no known allergies," see Entering "No Known Allergies."



You can review a patient's current allergies in several places:

- On the Cover Sheet, under Allergies / Adverse Reactions
- From any other tab, click the Postings button if it shows the letter "A"
- On the Orders tab under the "Allergy" service
- On the Enter Allergy Information dialog, click the Current button

To enter an allergy, follow these steps:

1. Click the **Orders** tab.
2. In the Write Orders list box, click **Allergies**.
3. In the dialog that appears, select the causative agent. You may type the word or part of the word (a minimum of three characters is required) you are searching for and click Search. In the list that appears, click the causative agent and click OK. The search for a causative agent now includes a breakdown of the different files where a match was found, and encourages the user to select from the most preferable source first. The list of matches is returned as a tree view grouped by file. The DRUG INGREDIENTS file has also been added to this search.

   Note: If you need to select a different causative agent, click the button with three dots on it to bring up the search dialog again.
4. In the new dialog that appears, select the reaction type.
5. Enter a reaction date and time if different than now.
6. Select whether this is an observed or historical allergy.

7. If it is a historical allergy, skip to step 9. If this is an observed allergy, select a severity.
8. Select the signs or symptoms of the reaction.

   Note: A date/time dialog will appear each time you select a sign or symptom to record when it was observed. You can enter multiple symptoms or signs. To remove a symptom or sign, click on it in the Selected Symptoms box.
9. Enter a comment if desired.
10. Click **OK**.

No Known Allergies

These steps apply if you do not have a quick order for entering "no known allergies." To enter an assessment of “no known allergies,” use these steps:

1. Click the **Orders** tab.
2. Under Write Orders, click the appropriate order dialog (such as Allergies).
3. When the Lookup Allergies dialog appears, click **Cancel**.
4. In the upper left of the Enter Allergy Information dialog, click the box by **No Known Allergies**.
5. Click **Accept**.

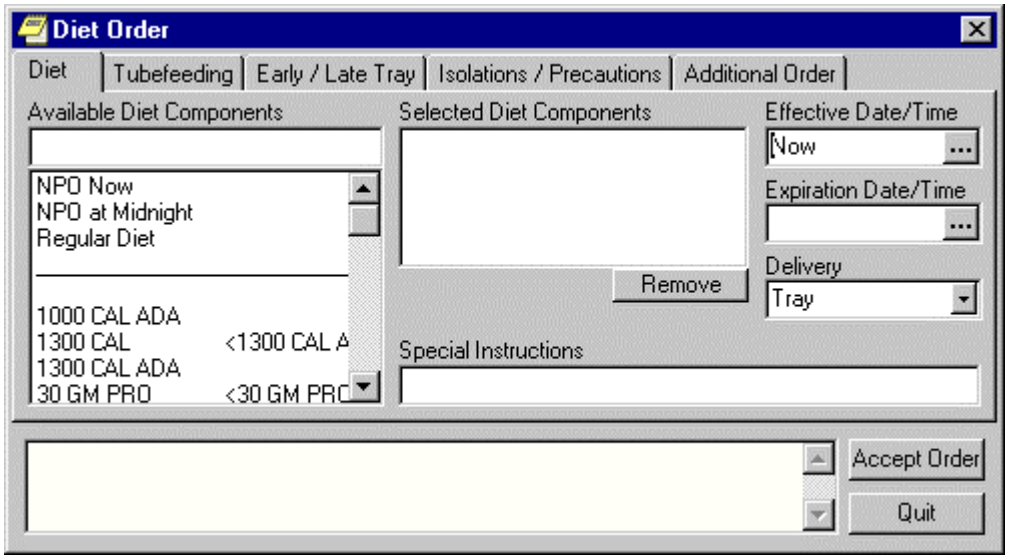
Consults

Consults are requests from one clinician to a hospital service or specialty for a procedure or other service. The Consults process involves the following steps, not all taken by the same individual or service:

1. The clinician orders a consult. While in a patient’s CPRS medical record, a clinician enters an order for a consultation or procedure. The ordering clinician may first have to enter Encounter Information.
2. The consult service receives an alert and a printed SF 513 report. The receiving service can then accept the consult, forward it to another service, or send it back to the originating clinician for more information.
3. The consult service accepts or rejects the consult request. The service can accept, discontinue or cancel the consult. Cancelled consults can be edited and resubmitted by the ordering clinician. A consult service clinician sees the patient.
4. The consult service enters results and comments. Resulting is primarily done using the Text Integration Utility (TIU).
5. The originating clinician receives an alert that the consult is complete. The results can now be examined and further action taken on behalf of the patient.
6. The Consult Report (SF 513) becomes part of the patient’s medical record. A hard copy can be filed and the electronic copy is on line for paperless access.

Diet

You can order several different kinds of diets from CPRS. The Diet Order dialog shown below has five tabs that offer different types of diet orders. The information you enter on each tab will create a separate order.



For instructions on how to write each kind of diet order, review the following procedure.

1. Click the **Orders** tab.
2. Click **Diet** in the Write Orders list box.

   Note: The Encounter Information dialog appears if no encounter information has been entered.
3. In the Diet tab, pick a diet from the Available Diet Components list box (Quick Orders are at the top of the list).
4. If you want the order to have the current date and time, go to step 5. Otherwise, enter the Effective Date/Time using the following steps:
   a. Click the button under Effective Date/Time.
   b. Choose the date. Arrows to the right and left of the month allow you to change the month. You then click on the desired day in the calendar shown.
   c. Choose a time. You can click on the hour and the minutes, choose Now, or choose midnight. Click **OK**.
5. Enter the Expiration Date/Time (use sub-steps a-c in step 4above).
6. Select Delivery method from the drop-down list under delivery.
7. Type in (free text) any special instructions.
8. Click **Accept Order**.
9. Click **Quit**.

   Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

You can also copy these orders to the Discharge Orders box.

IV Fluids

To order IV fluids, follow these steps:

1. Click the **Orders** tab.
2. Click IV Fluids in the Write Orders list box.

   Note: The Encounter Information dialog appears if no encounter information has been entered.
3. On the Solution tab, locate and click the solution you want.
4. Enter an infusion rate (free text) in ml/hr or text@labels per day.
5. Choose a priority: Routine, ASAP or STAT.
6. Enter a comment, if desired.
7. Select an additive, if desired (If no additive is desired, go to step 12.)
8. Click the **Additive** tab.
9. Locate and click the additive you want.
10. Enter an infusion rate (free text) in ml/hr or text@labels per day.
11. Choose a priority: Routine, ASAP or STAT.
12. Enter a comment if desired.
13. Click **Accept Order**.
14. When finished, click **Quit**.

    Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Lab Tests

To place an order for a lab test, do the following:

1. Click the **Orders** tab.
2. Click **Lab Tests** in the Write Orders box.

   Note: The Encounter Information dialog appears if no encounter information has been entered.
3. Locate and click the desired lab test in the Available Lab Tests list box.
4. If desired, change the default values for collection sample type, specimen type, and urgency (if you cannot change a default, the text to the right will be gray instead of black).
5. Select the collection time (today or tomorrow) and the frequency.
6. Enter the number of days that specimens should be taken.
7. Indicate whether you want to send the patient to the lab using the check box.
8. Click **Accept Order**.
9. When finished, click **Quit**.

   Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Overview of New CPRS/POE Functionality

To make it easier for providers to enter medication orders and have fewer orders that needed to be changed by pharmacy and sent back for provider signature, the Pharmacy Ordering Enhancement (POE) project was undertaken. The aim of this project was to make it easier for clinicians to enter medication orders and have the computer do the work in the background to also get pharmacists the information they need to fill the orders appropriately.

In doing this, ordering dialogs were redesigned to prompt clinicians for the information needed in a way that is more natural for them and will hopefully reduce the number of orders that need to be edited and sent back for signature again. Changes include removing the Dispense drug prompt and instead request a dose, using an API to ensure that the VA policy that a provider ordering a controlled substance must have a DEA or VA number, autocalculation of the quantity if a common dispense drug and a standard schedule are entered, and the availability of standard schedules to name a few.

In the CPRS GUI, the addition of a check box to quickly add PRN to a schedule, the capability to create complex doses for medications, and the display of the expected time of next administration plus a check box that enables the clinician to quickly place an order for to "Give First Dose Now" improve the interface. However, be careful that the NOW order and the original schedule do not overmedicate the patient.

In addition, another Medications item called Medications may have been added to your ordering menu. The Medications item can be used in addition to the existing dialogs for INPATIENT MEDS, OUTPATIENT MEDS, and IV FLUIDS. The only difference between this new dialog and the Inpatient and Outpatient dialogs is that Medications will automatically assign the ordering context (Inpatient vs. Outpatient) based on the selected patient's current admission/visit status. The Medications item provides a single dialog for medication orders instead of forcing the provider to pick among the INPATIENT MEDS, OUTPATIENT MEDS, and IV FLUIDS order dialogs. If the provider wants to use those specific dialogs, they are still available.

Note: With the new Medications item, the provider will not be able to write a prescription if the patient is currently admitted, or order an inpatient IV med for a patient in an outpatient clinic (i.e. you won't be able to write an order for the opposite context). Therefore, the old INPATIENT MEDS, OUTPATIENT MEDS, and IV FLUIDS items should still be available for the provider to use.

There are several other changes that are explained in the POE Release Notes.

Inpatient Meds

Ordering medications now uses two dialogs in the ordering process and eliminates the dispense drug prompt.

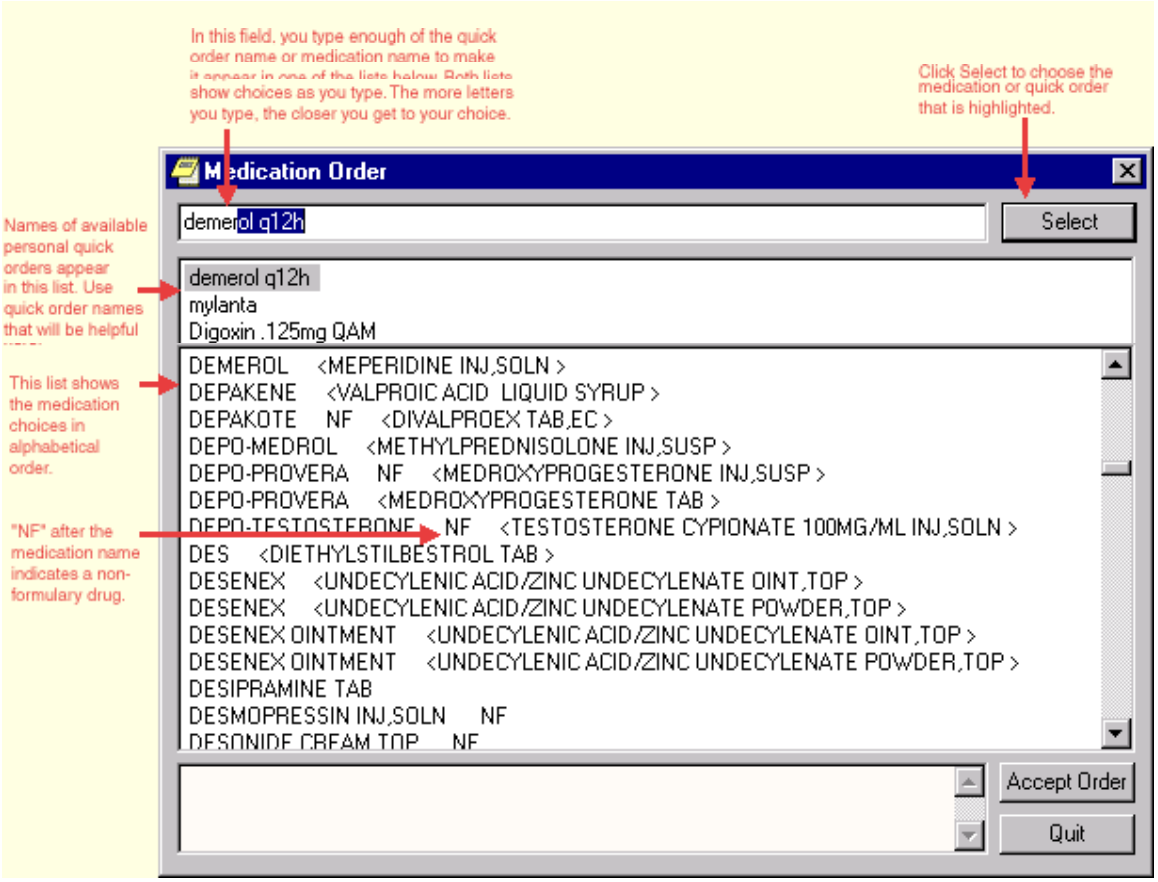
Simple Dose

To write a new Inpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

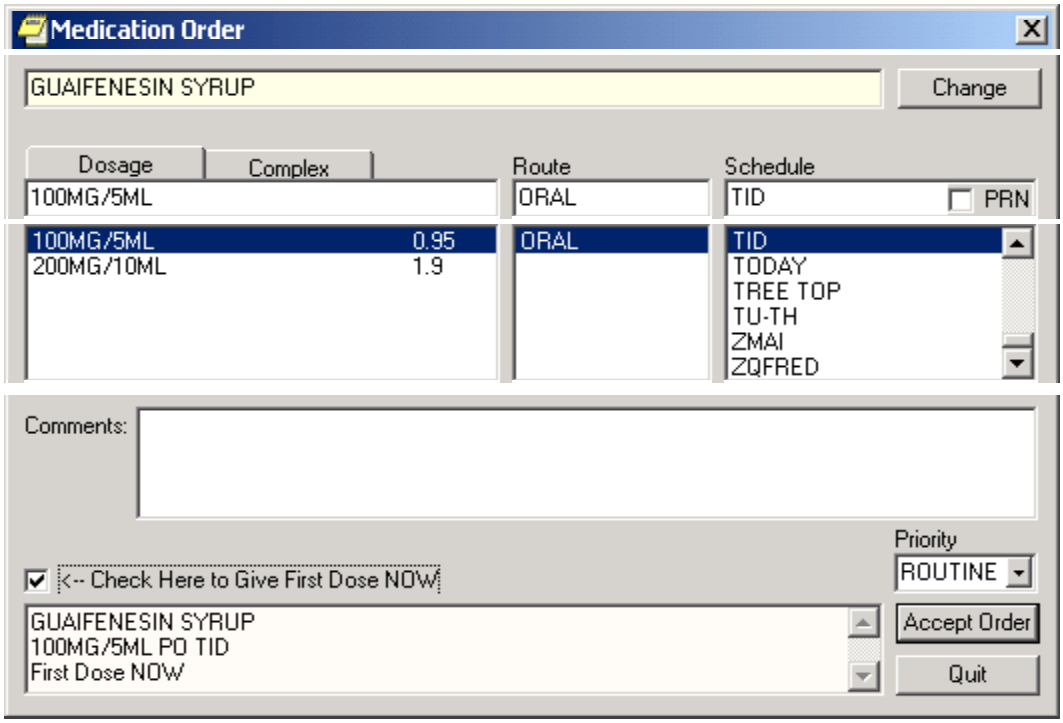
   Click the **Orders** tab and bring up the Inpatient dialog by clicking the appropriate item under the Write Orders box. CPRS displays the Medication Order dialog as shown in the graphic below.



2. Locate the desired medication or medication quick order. Click the quick order or medication name.

Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

3. Click the dosage field and select a dosage. (The associated cost is displayed to the right of the dosage.)



4. Select values for the Route and Schedule fields and click PRN if desired.
5. Add comments, if desired.
6. CPRS displays when the first dose of the medication is expected to be given. If you want to give the first dose now, click to place a check in the "Give First Dose Now" check box.

Note: Make sure that you are careful about using "Give First Dose Now". When you click the check box, a new order is created and sent to Inpatient Medications. Check to make sure the Now order and the original schedule you entered do not overmedicate the patient.

7. Click the drop-down arrow and select a Priority.

8. Click **Accept Order**.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you that the information is incorrect and shows you the correct type of response.

9. Enter another medication order or click **Quit**.

Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Complex Dose

To write a new Inpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

   Click the **Orders** tab and bring up the Inpatient dialog by clicking the appropriate item under the Write Orders box.

2. Locate the desired medication or medication quick order. Click the quick order or medication name.

Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

3. Click the **Complex** dose tab.

Note: Once you begin a complex order, you must remain on the Complex tab until you finish that order. Do not attempt to start from or switch back to the Dosage tab. If you do, all complex dosages will be erased and you will be forced to start again.

4. Click the dosage field and select the appropriate dosage.
5. Click the Route cell and enter the route (The default route should be the most common).
6. Click the Schedule cell and enter how often the medication should be taken (click PRN if desired).
7. Click the Duration cell and enter a number and select units (days is the default) a patient should use the specified dose.
8. Add the appropriate conjunction: And, Then, Except (Except is only for Outpatient Meds) or no conjunction for the final line.
9. Click in the dosage field in the next row and select a dosage.
10. CPRS will fill in the Route and Schedule fields. If necessary, click in and change the Route and Schedule cells.
11. Click and enter a duration and a conjunction.
12. Repeat steps 10-12 until you have completed the complex dose.

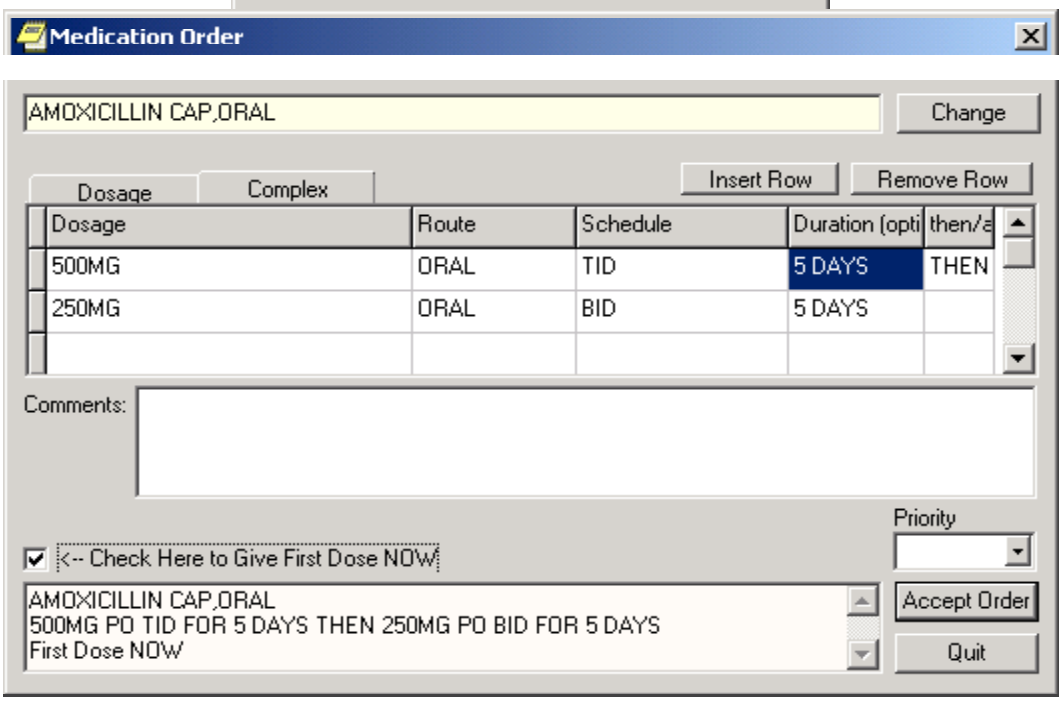
Note: You can also add or remove a row in the complex dosage. If you add a row, the new row will be placed above the selected row. To add a row, click the gray area in front of the row and click **Add Row**. To delete a row, click the gray area in front of the row to be deleted and click **Delete Row**.

13. Add comments, if desired.

14. CPRS displays when the first dose of the medication is expected to be given. If you want to give the first dose now, click to place a check in the " Give First Dose Now" check box.

Note: Make sure that you are careful about using “Give First Dose Now”. When you click the check box, a new order is created and sent to Inpatient Medications. Check to make sure the Now order and the original schedule you entered do not overmedicate the patient. If the provider checks “Give First Dose Now”, CPRS displays the following message: “First Dose Now is in addition to those listed in the table. Please adjust the duration of the first row, if necessary” as shown in the graphic below

15. Click the drop-down arrow and select a Priority.



16. Click **Accept Order**.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you that the information is incorrect and shows you the correct type of response.

17. Enter another medication order or click **Quit**.

Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Outpatient Meds

Outpatient meds can be written as simple doses or complex doses. To write a new Outpatient Medications order, use these steps:

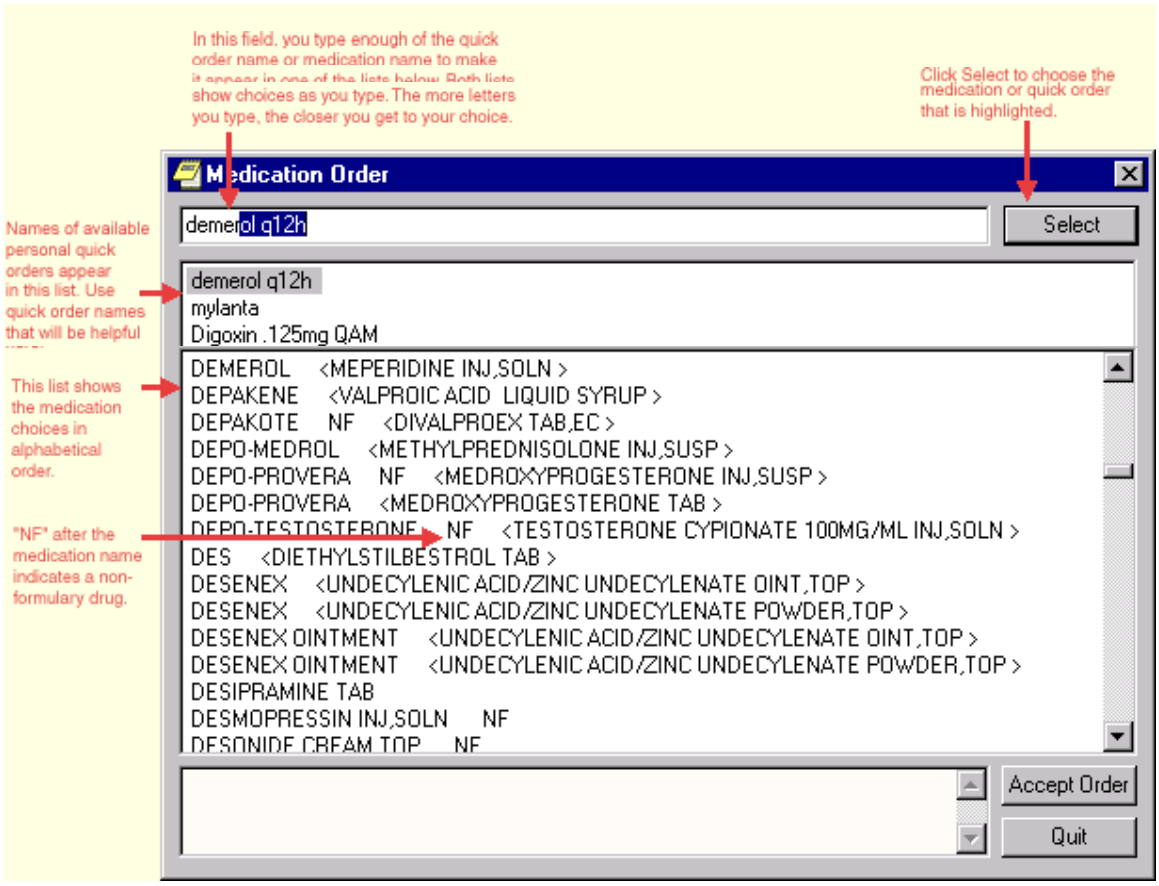
Simple Dose

To write a new Outpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

   Click the **Orders** tab and bring up the Outpatient dialog by clicking the appropriate item under the Write Orders box. CPRS will display the Medication Order dialog as shown in the graphic below.



Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

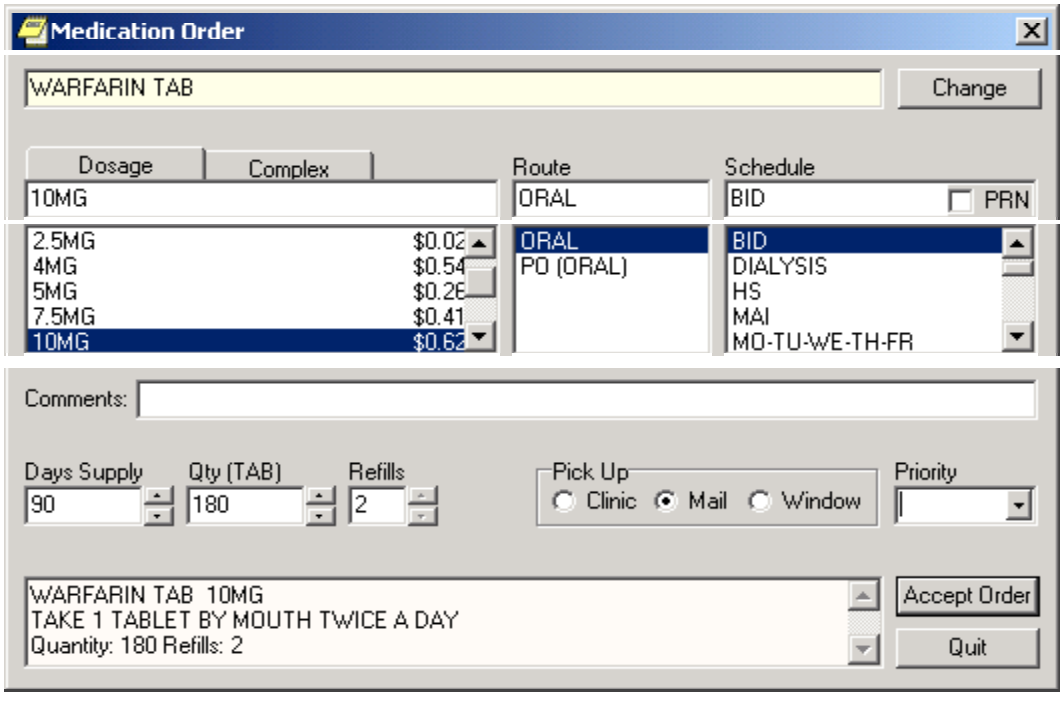
2. Locate the medication name or quick order name in the list box and then click it.

Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

3. Select the dosage. (The associated cost is displayed to the right of the dosage. See graphic under step 9.)
4. Select values for the Route and Schedule fields (select PRN, if desired).
5. CPRS puts in the default days supply and calculates the quantity based on the formula Days Supply x Schedule = Quantity. If necessary, highlight and change the numbers in these fields.

Note: If you change a number, CPRS will attempt to recalculate the other field, if possible.

6. Enter the number of refills.
7. Select where the patient should pick up the medication and the Priority.
8. You can also add a comment if desired.
9. Under certain circumstances, a check box may appear under the Days Supply field. If the medication is service-connected, make sure the box is checked.



10. Click **Accept Order**.

11. If you are finished ordering outpatient medications, click **Quit**.

Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Complex Dose

To write a new Outpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

   Click the **Orders** tab and bring up the Outpatient dialog by clicking the appropriate item under the Write Orders box.

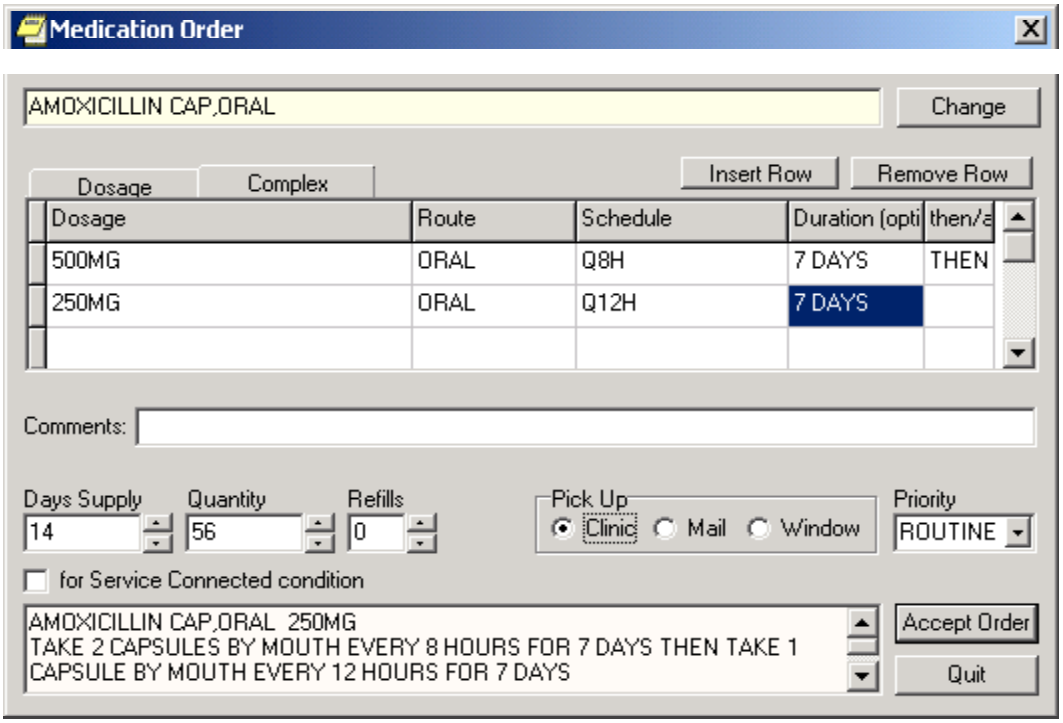
Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

2. Locate the medication name or quick order name in the list box and then click it.

Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

3. Click the **Complex** dose tab.

Note: Once you begin a complex order, you must remain on the Complex tab until you finish that order. Do not attempt to start from or switch back to the Dosage tab. If you do, all complex dosages will be erased and you will be forced to start again.



4. Click the dosage field and select the appropriate dosage.
5. Click the Route cell and enter the route (The default route should be the most common).
6. Click the Schedule cell and enter how often the medication should be taken (click PRN if desired).
7. Click the Duration cell and enter a number and select units (days is the default) a patient should use the specified dose.
8. Add the appropriate conjunction: And, Then, Except (Except is only for Outpatient Meds) or no conjunction for the final line.
9. Click in the dosage field in the next row and select a dosage.
10. CPRS will fill in the Route and Schedule fields. If necessary, click in and change the Route and Schedule cells.
11. Click and enter a duration and a conjunction.
12. Repeat steps 10-12 until you have completed the complex dose.

Note: You can also add or remove a row in the complex dosage. If you add a row, the new row will be placed above the selected row. To add a row, click the gray area in front of the row and click **Add Row**. To delete a row, click the gray area in front of the row to be deleted and click **Delete Row**.

13. CPRS puts in the default days supply and calculates the quantity based on the Days Supply x Schedule = Quantity. If necessary, highlight and change the number in these fields.

Note: If you change a number, CPRS will attempt to recalculate the other field, if possible.

14. Enter the number of refills.
15. Select where the patient should pick up the medication and the Priority.
16. You can also add a comment if desired.
17. Under certain circumstances, a check box may appear under the Days Supply field. If the medication is service-connected, make sure the box is checked.
18. Click **Accept Order**.
19. If you are finished ordering outpatient medications, click **Quit**.

Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Procedures

To order a procedure, use these steps:

1. Click the **Orders** tab.
2. Click **Procedure** in the Write Orders list box.

   Note: The Encounter Information dialog appears if no encounter information has been entered.
3. Locate and click the desired procedure in the Procedure list box.
4. Enter the reason for the procedure.
5. Select whether the patient is an inpatient or outpatient.
6. Select the Urgency, Place of Consultation, to whose attention you are sending it, and the Provisional Diagnosis.
7. Click **Accept Order**.
8. When finished, click **Quit**.

   Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Radiology and Imaging

To order any type of imaging, such as x-ray or a nuclear medicine exam or procedure, follow these steps:

1. Click the **Orders** tab.
2. Select Imaging in the Write Orders list box.

   Note: The Encounter Information dialog appears if no encounter information has been entered.
3. Click the desired imaging type in the Imaging Type list box.
4. Locate and click the desired procedure in the Imaging Procedure list box.
5. Select the appropriate modifiers from the Available Modifiers list. The list of Available Modifiers is in a combo box, which allows you to enter the first few letters of a modifier instead of scrolling through the entire list.

   Note: The modifiers are shown in a field to the left of the Selected Modifiers list. If you need to remove a modifier that you have selected, click the modifier, and then click Remove.
6. Select the appropriate criteria from the dialog's drop-down lists: Requested Date, Urgency, Transport, Category, and Submit To.
7. Click **Accept Order**.
8. When finished, click **Quit**.

   Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Lab Tests

To place an order for a lab test, do the following:

1. Click the **Orders** tab.
2. Click **Lab Tests** in the Write Orders box.

   Note: The Encounter Information dialog appears if no encounter information has been entered.
3. Locate and click the desired lab test in the Available Lab Tests list box.
4. If desired, change the default values for collection sample type, specimen type, and urgency. (If you cannot change a default, the text to the right will be gray instead of black).
5. Select the collection time (today or tomorrow) and the frequency.
6. Enter the number of days that specimens should be taken.
7. Indicate whether you want to send the patient to the lab using the check box.
8. Click **Accept Order**.
9. When finished, click **Quit**.

   Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Vitals

You can enter Vitals information into CPRS from the Cover Sheet. The Cover Sheet displays the patient's most recent vitals information in the lower central part of the Cover Sheet.

To enter a patient's vitals information, follow these steps:

1. Click on a value in the Cover Sheet's Vitals area.
2. Click **Enter Vitals** in the upper left corner of the dialog that appears.

   Note: If the visit has not been defined, the Visit Selection dialog appears. You must choose either a previous visit or define a new visit to enter the vitals.
3. If necessary, enter the encounter information and click OK.

   Note: The Enter Vitals for - Patient Name (Patient Name will be replaced with the patient's name, such as John Doe) dialog appears. You will enter the vitals information into this dialog's fields.
4. Enter the desired information.

   Note: You can change the temperature, weight, and height units. To do this, you click on the drop-down list arrow and select the units you want.
5. Click **OK** when finished.
6. When you are done viewing the patient's vitals, click on the close box (with the "X" on it) in the dialog's upper right corner.

Event-Delayed Orders

Some orders can also be placed as event-delayed orders. With CPRS, you can place orders that will only become active when a certain event, such as an admission occurs.

For outpatients, admission is usually the only event needed. For inpatients, you can have orders that become active on admission, transfer, or discharge.

You can also copy existing orders to event-delayed orders.

To place an event-delayed order, use the following steps:

1. Click the **Orders** tab.
2. In the Order Sheet list box on the left of the Orders tab, click the event, such as **Admit**, **Transfer** or **Discharge**, which will activate the order you will enter.
3. Enter the order as you normally would.

Copying Existing Orders

With CPRS, you can copy an existing order to create a new order.

The copied order can be released immediately or you can set it to be delayed until an event, such as admission, transfer, or discharge, occurs.

To copy an order, use these steps:

1. Click the **Orders** tab.
2. Select the order or orders you want to copy. Hold down the CTRL key and click on the desired orders to select more than one order. Hold down the SHIFT key and click on the first and last desired orders to select a range of orders.
3. Select **Action | Copy to New Order** or right-click on a selected order and select Copy to New Order.
4. In the dialog that appears, click whether you want the orders released immediately or if they should be delayed.
5. If you chose Release Copied Orders Immediately, skip to step 7. If you chose Delay Release of Copied Orders, choose the event under that choice that should release the orders.
6. If necessary, choose the specialty or admission location.
7. If the order does not require changes, click Accept. If the order requires changes, click Edit, make the changes, and click Accept.
8. Repeat steps 6 and 7 as needed for the orders selected.
9. When finished, you can sign the orders for wait until later.

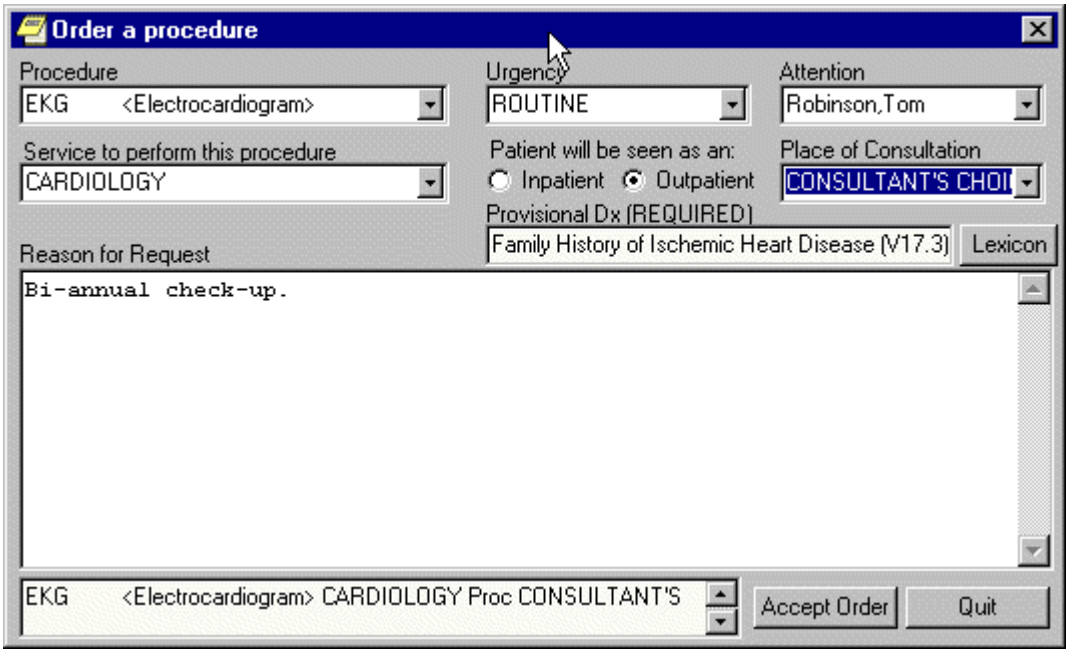
Ordering Actions

The following actions are available from the Action menu on the Orders tab (or by right-clicking). If an action is grayed-out, you can't perform that action on this order.

- Change
- Discontinue / Cancel
- Hold
- Release Hold
- Renew
- Flag
- Unflag
- Acknowledge
- Release without Signature
- Sign

New Procedure from the Orders Tab

1. Select the **Orders** tab.
2. In the Write Orders field, click on **Procedure**.
3. If the Provider & Location for Current Activities dialog opens, complete contact information.
4. Select a procedure. The Order a Procedure dialog opens.



5. Type in the reason for the procedure request in the Reason for Request text field.

6. Make sure the following fields show the correct information. Make changes as necessary:
    - Service to perform this procedure
    - Patient will be seen as an Inpatient/Outpatient
    - Urgency
    - Place of Consultation
    - Attention
    - Provisional Diagnosis (may be required depending on the procedure)
7. Click **Accept Order**.

8. If there are no other procedure orders for this patient, click Quit.

You may sign the procedure request now or later.

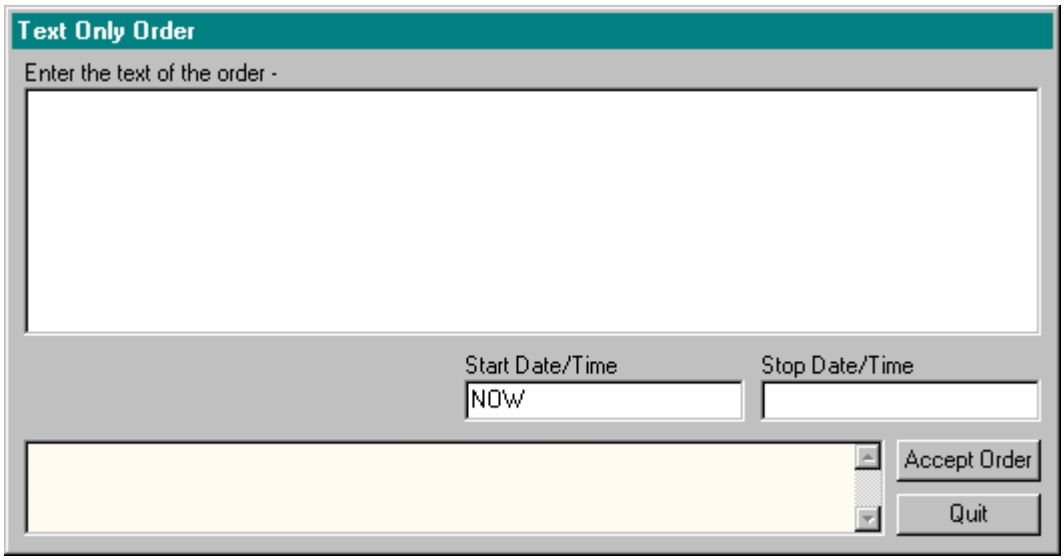
Text Orders

Parameters, Activity, Patient Care, and Free Text orders are different kinds of orders that are placed for nursing and ward staff to take action on. They print only at the patient's ward/location, and are not transmitted electronically to other services.

Examples of these various kinds of nursing orders are:

Order Type	Order
Parameters	Vital signs
Activity	Bed rest, ambulate, up in chair
Patient Care	Skin and wound care, drains, hemodynamics
Free text	Immunizations

Predefined nursing orders (quick orders) may be available under various sub-menus. Selecting the Text Only option from the Order Screen may also be used to compose nursing orders. These orders require the ward staff to take action to complete the request.



Ordering a New Consult from Orders tab

1. Select the Orders tab.
2. In the Write Orders dialog, select Consult.
3. If the Provider & Location for Current Activities dialog opens, complete the contact information.
4. Select a type of consult from the list in Consult to Service/Specialty field.
5. The reason for the consult is automatically generated in the Reason for Consult field.
6. Make sure the following fields show the correct information:
    - Consult to Service/Specialty
    - Patient will be seen as an
    - Urgency
    - Place of Consultation
    - Attention
    - Provisional Diagnosis
7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click **Quit**.

You may sign the consult now or later.

Notes

The Notes tab gives you quick access to the Progress Notes for a specific patient. The list of documents in the Notes tab is in a tree structure instead of a simple list. Highlight any note listed in the left field to view the text of the note in the right field. Addenda are separately selectable and are displayed as a page with a plus sign behind a note page (See highlight below.) Notes with Addenda have a clickable plus sign. Hold the mouse pointer over a listing to see the entire line of the listing. The Progress Note that is highlighted is displayed on the right.

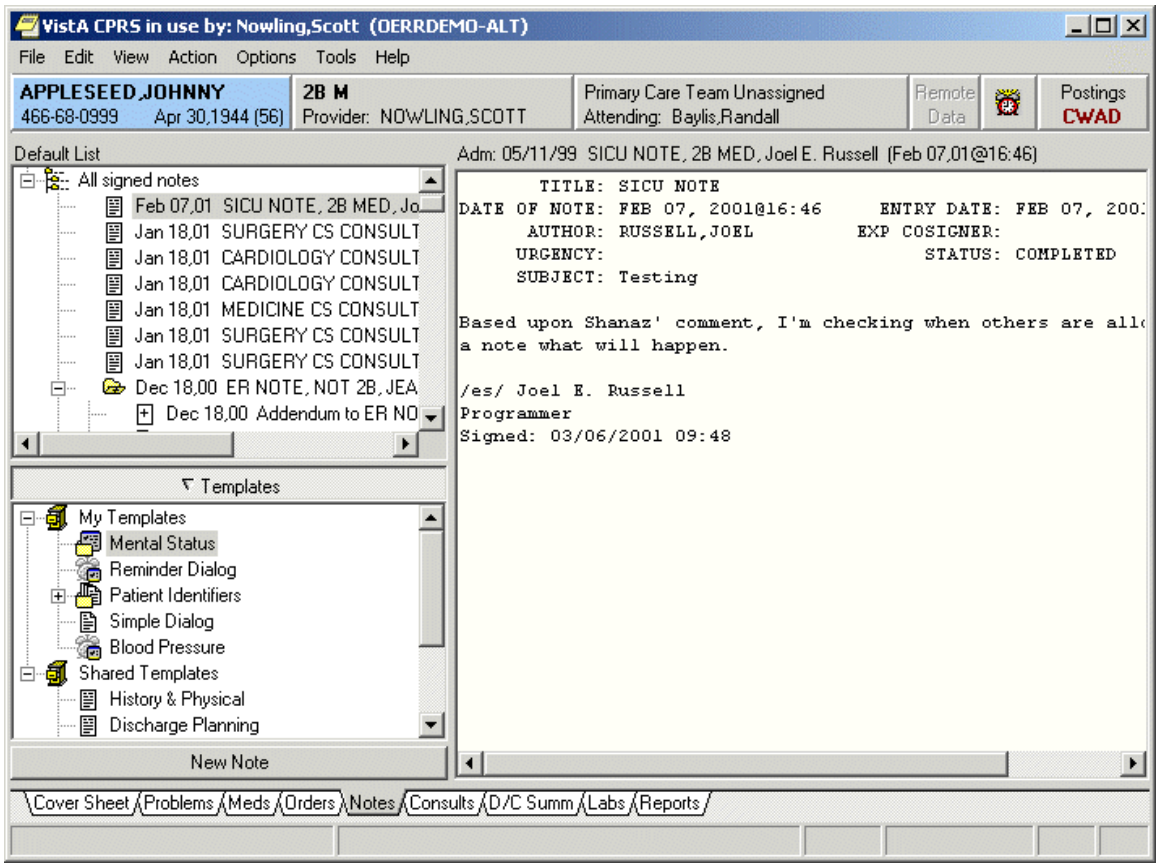
Right-click in the Notes text and you may select the “Find in Selected Note” option from the popup menu. This option allows you to search the displayed text. A “Replace Text” option is also available, but it is only active when a note is being edited.

Interdisciplinary notes are grouped under the original note and are marked with a yellow folder icon with a plus sign on it. Interdisciplinary notes are notes produced by several different departments or disciplines (physicians, addenda, consults, emergency room, pharmacy, dietitians, etc.)

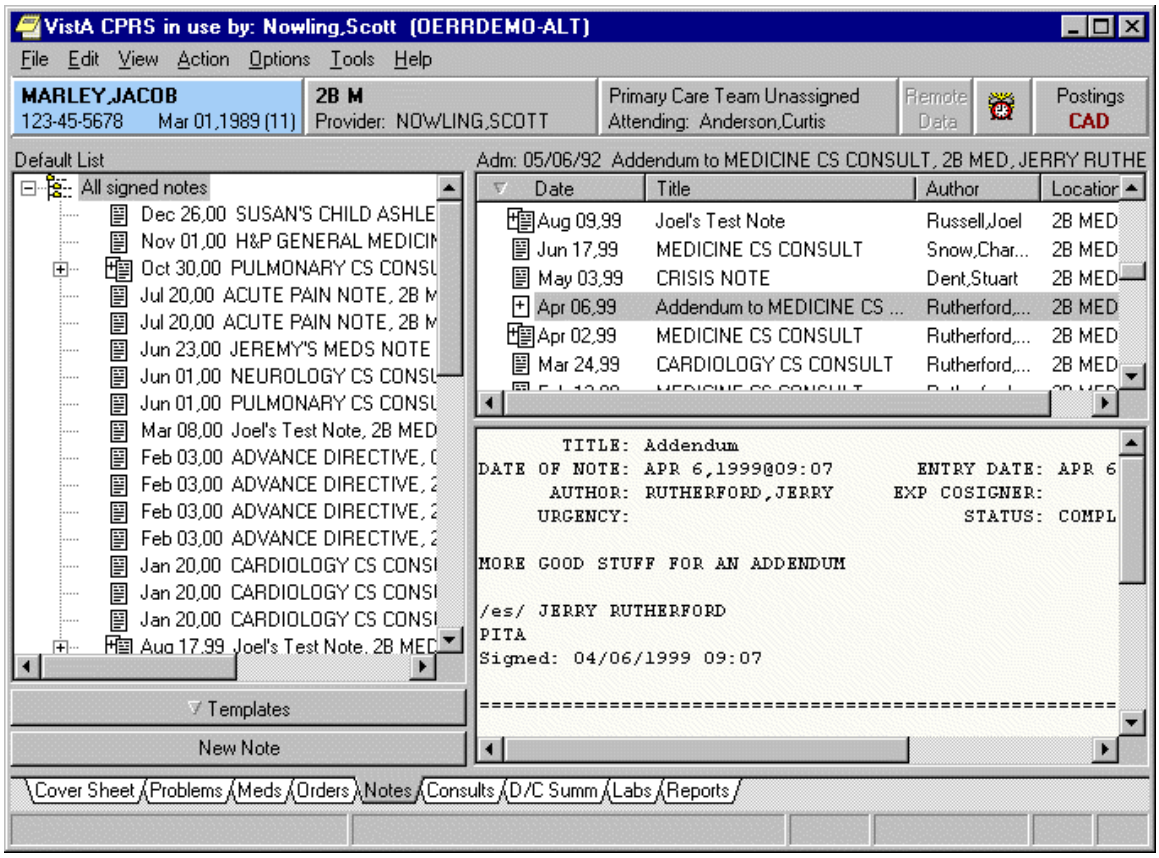
Click on the View and Action menus to see the available options. Double click the plus sign to expand the list. Once expanded, any note may be selected and viewed.

You can also click the New Note button to create a Progress Note. You may also have to enter encounter information if the visit has not been defined.

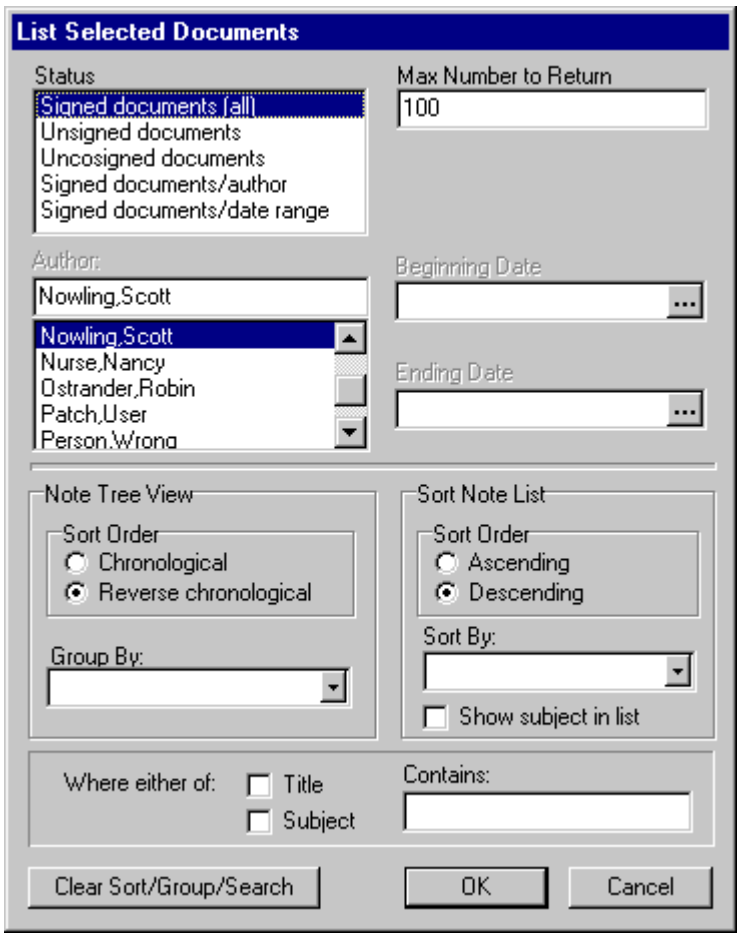
The Templates drawer is available without opening or editing a Note. This allows templates to be copied and used in other word processing fields throughout CPRS. The Templates Icon Legend is available from the Templates Drawer. Right-click in the Templates drawer and select Templates Icon Legend.



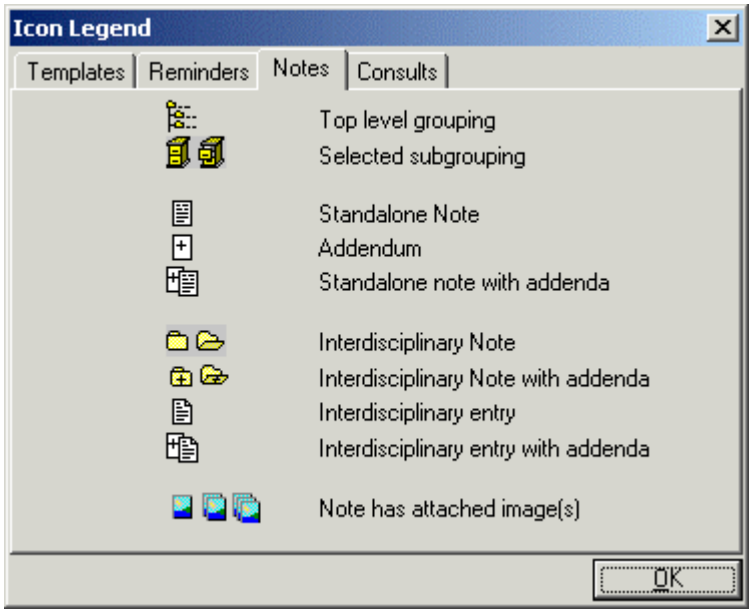
Select a grouping node (for example "All signed notes") in the tree to display a second list of all the documents falling under that grouping node. This second list can be sorted by clicking on the column headings (Date, Title, Author, Location).



The Custom View dialog (**View | Custom View**) has been greatly expanded, allowing the items in the tree to be grouped and sorted in a variety of ways. All custom view selections can be saved as the user's default view (**View | Save as Default View**).



The Notes tab on the Icon Legends dialog includes a description and explanation of the different icons that appear on the Notes tree view. To access the Icon Legend, click **View | Icon Legend**.



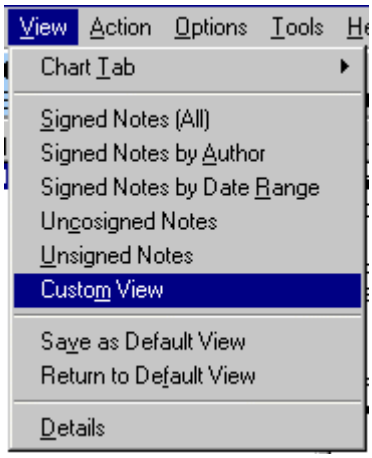
Changing Views on the Notes tab

Changing the view of the Notes tab allows you to focus the list of notes on one of several criteria. Focusing the list will speed up the selection process.

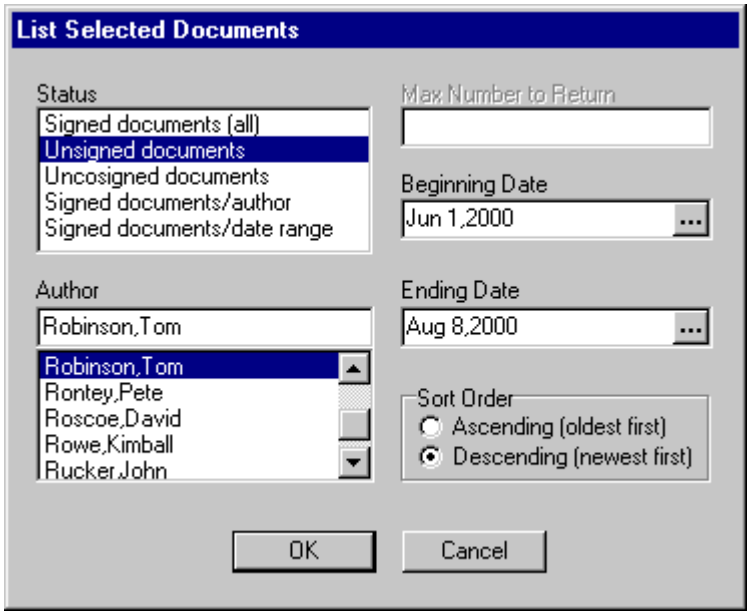
You may change the Orders List view to only include the following problems:

- Signed Notes (All)
- Signed Notes by Author
- Signed Notes by Date Range
- Uncosigned Notes
- Unsigned Notes

To change the view, click on View on the menu and select the desired list items.



You may select the Custom View option on the menu to further focus the list of notes you wish to have displayed. From the List Selected Documents dialog, you may choose to display notes by any combination of Status, Author, and date range.



Encounter Information

CPRS has two kinds of encounter information: visit information and encounter form data.

For each visit (or telephone call) with a patient, you need to enter the provider, location, date, and time. CPRS requires this information before you can place orders, write notes, add to the problem list, and so on.

The parameter, ORWPCE ANYTIME ENCOUNTERS, can be set to allow encounters to be entered on the Notes tab when no note is being entered. This will allow encounter entry (at the time of the visit) for dictated notes. This parameter can be set at the User, Service, Division, and System levels. Note that this will edit the encounter associated with the current location and time, which is not necessarily the encounter associated with the currently displayed note.

To receive workload credit, you must enter the encounter form data, including the following information, for each encounter:

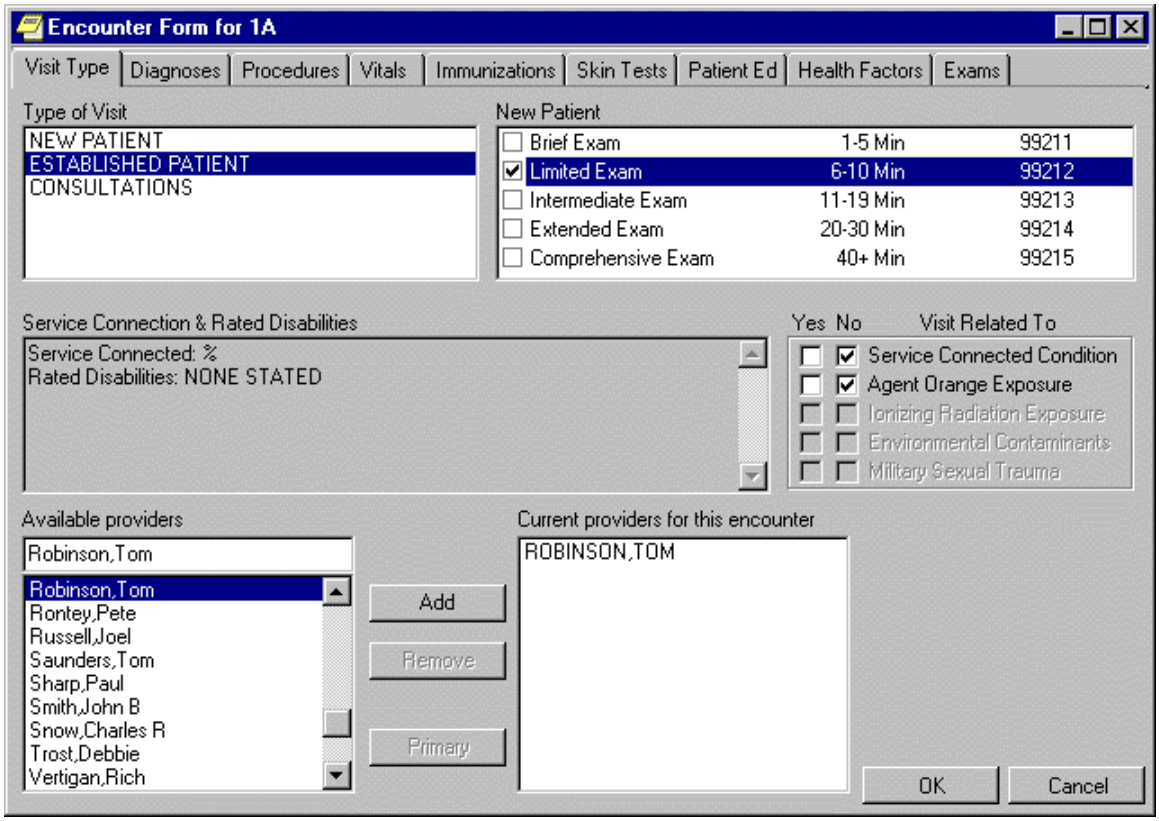
- Service connection
- Provider name
- Location
- Date
- Diagnosis
- Procedure
- Visit Information

CPRS shows the encounter provider and location for the visit on the Visit Encounter box, identified in the graphic by the pointer. You can access this box from any chart tab.

If a provider or location has not been assigned, CPRS will prompt you for this information when you try to enter progress notes, create orders, and perform other tasks.

Encounter Form Data

For workload credit and to gather other information, you enter encounter form data when you create a progress note, complete a consult, or write a discharge summary. When you create one of these documents, an Encounter button appears. Click this button to bring up the Encounter Frame or you will be prompted for encounter information when you try to sign the note or exit the current patient's chart.



The Encounter Frame has eight tabs:

- Visit Type
- Diagnoses
- Procedures
- Vitals
- Immunizations
- Skin Tests
- Patient Education
- Health Factors
- Exams
- Global Assessment of Functioning (GAF) (The GAF tab is only available if specific Mental Health patches are installed and if the location is a mental health clinic.)

Your site defines forms from Automated Information Collection System (AICS) application to be used with the Encounter Frame. Once your site has defined the necessary forms and associated them with the Encounter Frame, each tab has a number of general categories on the left. When you click on a general category on the left, the corresponding items appear in the list box on the right.

For example, the Visit Type tab might have New Patient, Established Patient, and so on listed in the left list box. The list box on the right would have check boxes for the different types of patient appointments, such as 15 minutes, 30 minutes, 45 minutes, and so on.

Even if you don’t have the form defined yet, you can click on the Other button to get a list of choices that are active on your system.

With the forms defined and associated with the Encounter Frame, you can use the Encounter Frame just like a paper form, clicking the appropriate tab, category, and check boxes to mark items or clicking Other and selecting the appropriate choice.

If these forms have not been defined, ask your Clinical Coordinator about it. When the forms have been created, you can quickly enter patient care encounter data.

Entering Encounter Form Data

To receive workload credit, enter encounter form data when you create a new Progress Note, complete a Consult, or write a Discharge Summary for the selected patient.

> **Note**: Once a note, summary, or consult has been completed, you can only change encounter information directly through Patient Care Encounter (PCE.)

To enter encounter form data, follow these steps:

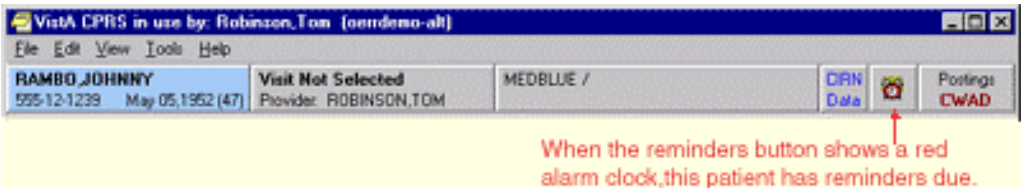
1. Click the appropriate tab: Notes, Consults, or D/C Summ.
2. Click **New Note**, **New Summary** or select **Action | Consult Results....**
3. Type in a title for the note or summary or select one from the list.
4. Click **Encounter**.
5. Click the tab where you want to enter information (Type of Visit, where you can also enter the primary and secondary providers, Diagnoses, where you can have diagnoses automatically be added to the Problem List, Procedures, Vitals, Immunizations, Skin Tests, Patient Ed., Health Factors, or Exams).
6. Click the appropriate category in the list box on the left and then click the check boxes by the appropriate items in the list box on the right. If the section name you want is not shown or the list boxes are empty, use the search feature. To search, click on the Other <Tab Name>. (Each tab's button will be labeled differently.) Locate and double-click the needed item. Some tabs have a simple list to choose from. Diagnoses and Procedures have a search function. On these tabs, you need to enter the beginning of a term and click Search before double-clicking.

   > **Note**: The Type of Visit and Vitals tabs are different. Type of Visit has no button, and Vitals has a Historical Vitals Details button that brings up a dialog containing a graph and a listing of past vitals taken.
7. Enter any additional information as needed. Several tabs have additional features, such as drop-down lists for results of exams, severity of problems, and so on.
8. Fill in information for other tabs as needed by repeating steps 2-6.
9. When finished, click **OK**.

Clinical Reminders

There are three main ways you can know that patient has reminders:

- The reminders button near the top right of the CPRS form may have one of five icons on it. If you click this button, you bring up the dialog that shows a reminders tree view.



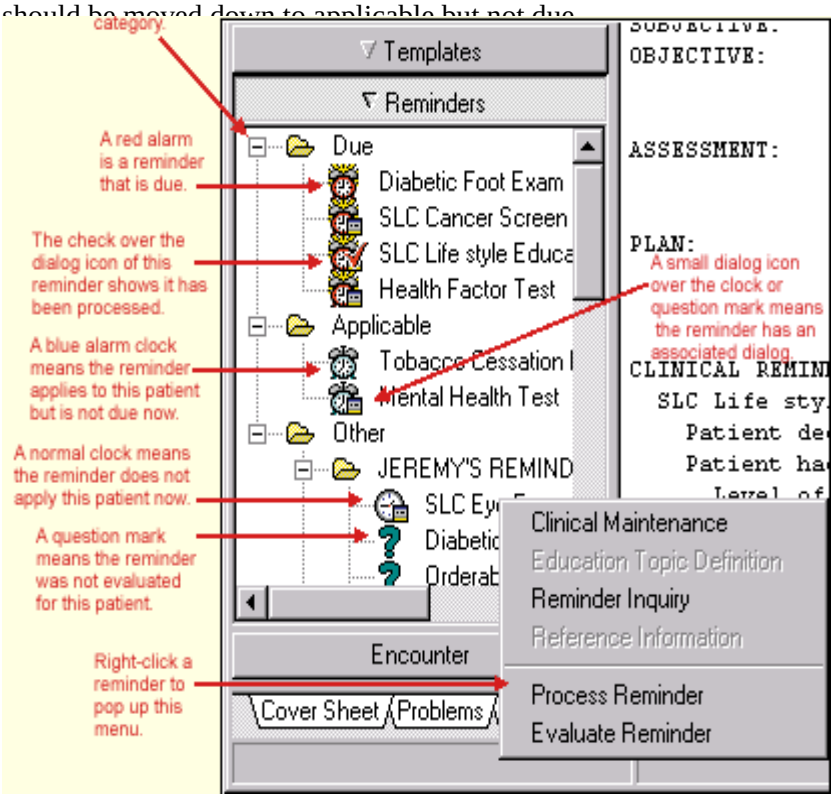
- The coversheet has an area specifically for reminders.
- After you begin a new progress note, you can open a reminders drawer to check on the reminders for this patient. If you click the reminders drawer, you bring up the dialog that shows a tree view of due, applicable, and other reminders.

The Reminders Drawer

After you begin a new note, you will see the Reminders drawer. Click to open the drawer and see a tree view of reminders that are due, applicable, and other reminders as shown here. The Due category is automatically expanded when you open the Reminders drawer, while the Applicable and Other categories are not.

> **Note**: Before you can process a reminder, the CAC or someone else must create a dialog in a similar position at your site. A dialog image over the clock or question mark icon shows that a reminder has an associated dialog.

After you process a reminder but before you reevaluate it, a check is placed over the reminder to show it has been processed. If you evaluate the reminder again, the reminder should be moved down to applicable but not due.



Click on a reminder to bring up the Reminders Processing dialog and process a reminder.

Right-click on a reminder to get the following options:

- Clinical Maintenance - shows the possible resolutions and the findings associated with the reminder.

- Education topic definition - may list the education topics that have been defined for a reminder. You can select a topic to view the desired education outcome and any standards.
- Reminder Inquiry - will show the reminder definition describing which patients are selected for this reminder.
- Reference Information - can list web sites with additional information.

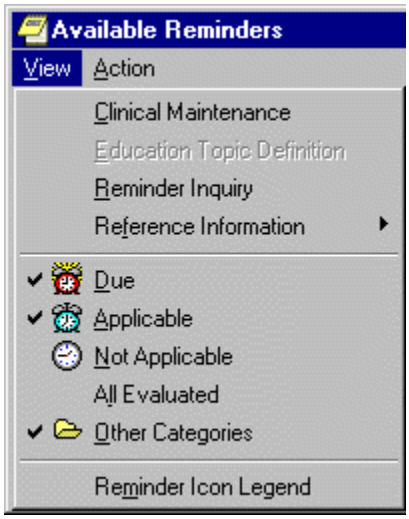
Each of these options will bring up a window. When you are finished with the window, click Close. For more information on Clinical Reminders, refer to the *Clinical Reminders Manager Manual* and *Clinical Reminders Clinician Guide.*

Reminders Processing

You will process Reminders using the Reminders Processing dialog. It shows the possible activities that can occur during a visit and that can satisfy the reminder. You may need to enter additional information.

If a Reminder dialog generates Primary Care Encounter (PCE) data for the current encounter, the user will be prompted to enter the primary encounter provider when clicking the FINISH button, if one is needed (depending on the PCE data created, and the setting of the ORWPCE DISABLE AUTO CHECKOUT parameter).

In the reminder tree dialog, under the View menu, there are now five new menu options for determining which folders will appear in the reminder tree. These menu options, Due, Applicable, Not Applicable, All Evaluated, and Other Categories will be checked if that folder is to appear in the tree. Individual users can set which folders will appear by selecting each menu item.

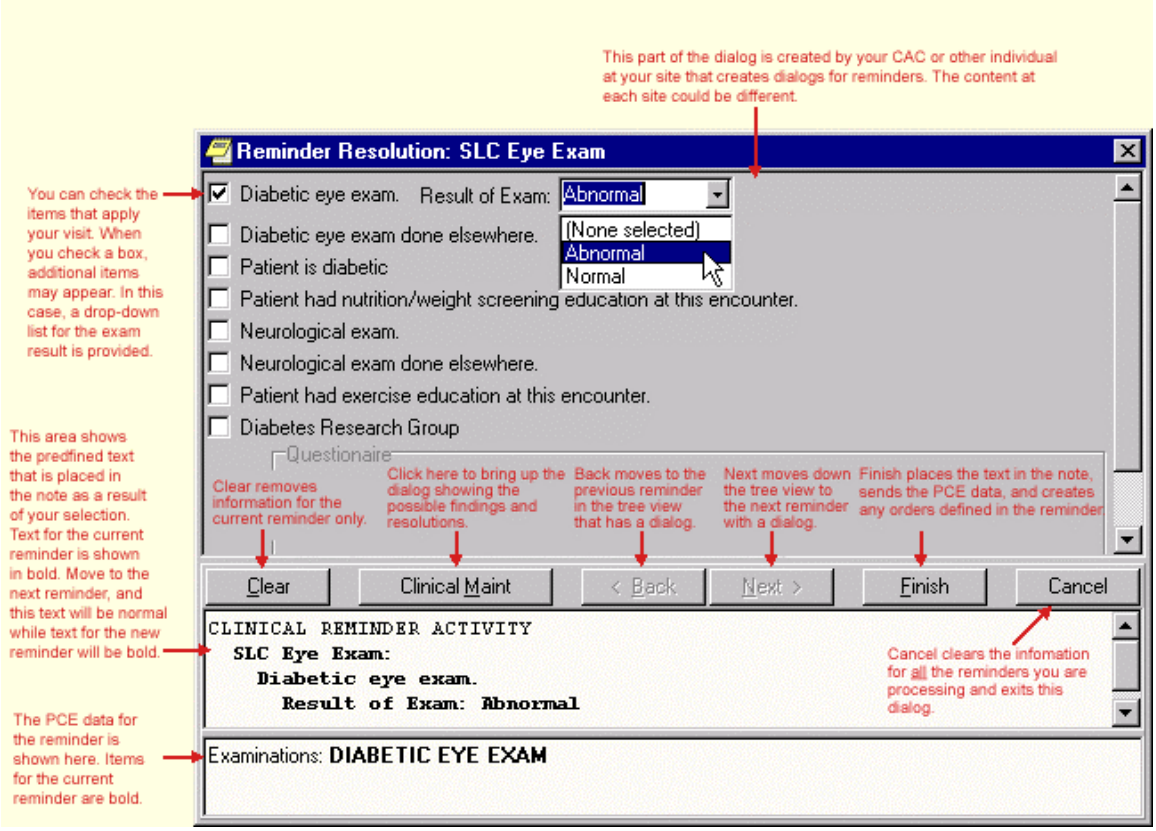


When you check an item on a Reminder dialog, it may expand to enable entry of more detailed information, such as dates, locations, test results, etc., or orders that you might often place based on a response. The information depends on how the dialog was created at your site. Reminder Dialog elements that allow only one choice per dialog group appear as radio buttons.

When you click a checkbox or item, the associated text that will be placed in the progress note is shown in the area below the buttons. Patient Care Encounter (PCE) data for the item is shown in the area below that.

Text and PCE data for the reminder you are currently processing are in bold.

When vital signs are entered in Reminder Dialogs, a prompt appears when the Finish button is pressed requesting the date and time the vital signs were taken. This prompt will default to the date of the encounter.



- Required fields will no longer be checked on a Reminder dialog unless at least one entry has been made on the dialog. This will allow users to skip Reminders that are not intended for processing.
- Reminder dialog groups can now be set to NONE OR ONE SELECTION, which will allow up to one entry in a group, but does not require an entry. PX*1.5*2 is required to change the reminder dialog definition.
- Required prompts and template fields will be marked with an asterisk (*) to indicate that they are required. A message at the bottom of the Reminder dialog states "* Indicates a Required Field".

Reminder Dialogs have a Visit Info button. It opens a dialog that allows the user to enter service-connected information, as well as the vital sign entry date/time. If service connected information is required for the encounter and note title, this dialog will automatically appear when you click Finish.

Processing a Reminder

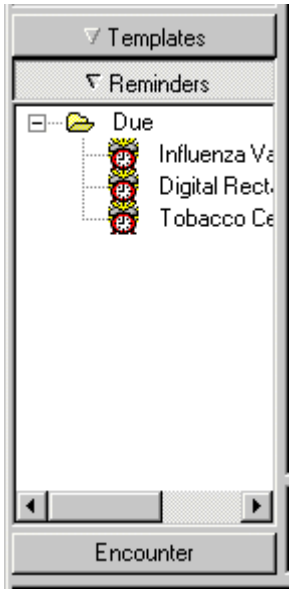
To process a reminder for a patient, complete the following steps:

1. If you have not already, begin a new progress note by clicking the Notes tab, then New Note, and then select a note title. (If prompted, enter the encounter location and provider.)

2. Click the Reminders drawer to open its tree view or click the Reminders button to open a tree view of the reminders for this patient.

3. Click the plus sign to expand the hierarchy where needed and click the reminder you will process. You will then be presented with the dialog for processing reminders.

   Note: If you click the Reminders button, you can also choose Action | Process Reminders Due to begin with the first reminder due.



4. Read the choices, click the checkboxes in front of the items that apply to this patient, and enter any additional information requested such as comments, diagnoses, and so forth.
5. When you are finished with this reminder, click another reminder or click Next to move to the next reminder.
6. Repeat steps 4 and 5 as necessary to process the desired reminders.
7. When you have processed all the reminders you want to do at this time, click Finish.
8. Review and finish your progress note and enter any information necessary in order dialogs.

Completing Reminder Processing

After you have entered all the information, you can finish processing the reminders.

When you finish, the following things will happen:

- The predefined text is placed in the note you have begun writing.
- The encounter information to is sent to Patient Care Encounter (PCE) application for storage.
- If there are orders defined in the dialog, it will also create the orders. If the orders require input (if they are not predefined quick orders without prompts), the order

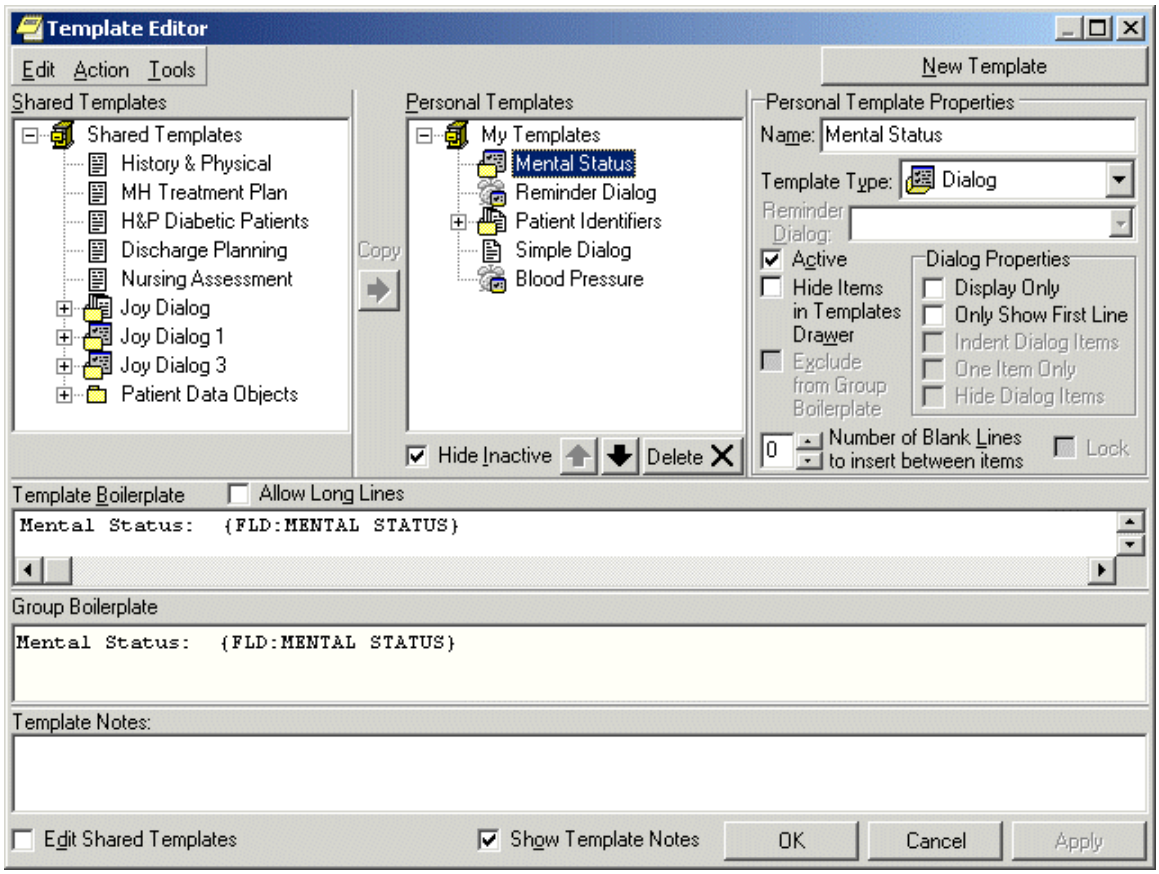
dialogs will come up so that you can complete the orders. You will then have to sign any orders that are created.

To finish processing reminders, click Finish.

Document Templates

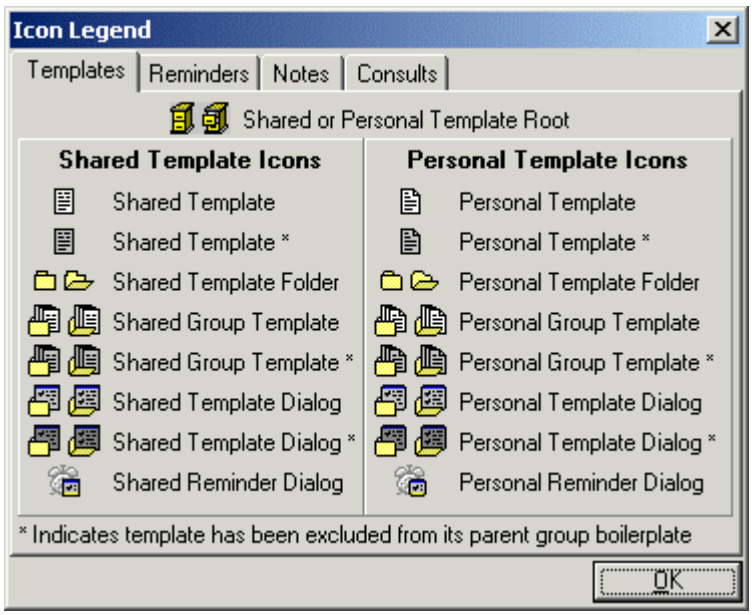
With the CPRS GUI, you can create document templates to quickly add commonly used text and Template Fields when writing or editing Progress Notes, completing Consults, or writing Discharge Summaries. Template import and export utilities are available through the Template Editor Tools menu. Word® documents can be imported and converted into templates. A Print button has been added to the Preview Templates dialog so that you may either view the templates on the screen or send it to a printer. You can refresh the dialog by selecting the Tools | Refresh menu option of the Template Editor.

The Template Editor is shown in the following graphic.



Note: A Line and Column indicator have been added to the Template Editor window. The indicator is located under the Personal Templates area and indicates the cursors position in the Boilerplate Template.

The Templates tab on the Icon Legends dialog includes a description and explanation of the different icons that appear on the Templates tree view. To access the Icon Legend, click **Tools | Template Icon Legend**.



Personal and Shared Templates

You can create and use your own templates or use shared templates that your Clinical Coordinator creates:

Personal templates.

Authorized users can create personal templates. You can copy and paste text into a template, type in new content, add Template Fields, or copy a shared template into your personal templates folder. A shared template that you simply copy into your personal templates folder without changing continues to be updated whenever the original template is changed or modified in the Shared Templates folder. Once you personalize or change the copy of the shared template in your personal templates field, the icon used to represent it changes and it becomes a personal template. From that moment on, the personal template is not related to the shared template and is not updated with the original. In the tree view, personal template and folder icons have a folded upper right corner.

Shared templates.

Only members of the Clinical Coordinator Authorization/Subscription Utility (ASU) class can create shared templates. Shared templates are available to all users. Coordinators can copy and paste text into a template, type in new content, add Template Fields, or copy a personal template and then modify it as needed. In the tree view, shared template and folder icons do not have a folded corner.

> **Note**: When you install CPRS, a copy of all your existing boilerplate titles is placed in the inactive boilerplates folder under shared templates.

Clinical coordinators can arrange the boilerplate titles copied into the shared templates to be used as templates, use them to create new templates, or make them available to users by moving them out of the inactive folder. You will not see the inactive folder or its templates unless you choose to make the folder active.

(To see the boilerplates folder, clinical coordinators should go into the templates editor, make sure Edit Shared Templates is checked, uncheck Hide Inactive under shared templates, and click the plus sign beside the shared icon.) Shared Templates include a Lock property that, when set, will prevent users from making personal changes. The status of the Lock

property is displayed in a checkbox on the Template Editor dialog. If the Shared Templates root template is locked, no shared templates can be modified. For more information on boilerplates, refer to the *Text Integration Utility User Manual*.

Mark a Template as Default

You may select and mark a template or folder to be your default. Right-click on any template and select Mark Template as Default from the menu. This convenience feature allows you to make a frequently used template easier to access. Default templates will automatically be selected the first time you open the Templates Drawer and can be jumped to at any time with the Go to Default Template option. Each tab (Notes, Consults, and D/C Summ) can have its own default.

Go to the Default Template

Once you have selected a default template, you may right-click from any template and select Go to Default Template from the menu. The highlight will jump to your default template so that you may access it.

Hide Items in Dialogs

Click on this check box and children templates are no longer available from the template drawer. Only the parent group template, dialog, or folder is available.

Display Only

Click this check box to make individual parts of a dialog as display only. When a template is display only, the check box is removed and the item is used for information or instructions

Only Show First Line

Click on this check box and the template will display only the first line of text followed by an ellipsis (...). The ellipsis indicates that more text exists. Hold the cursor over the line of text and a Hint box displays the complete text. This feature gives you the ability to have long paragraphs of text that do not take up a lot of room on the template. If selected, the entire paragraph is be inserted into the note.

Indent Dialog Items

Clicking on this check box affects the way that children items are displayed on the template. When selected, this feature gives the ability to show hierarchical structure in the dialog. All of the subordinate items for the selected item are indented.

One Item Only

Clicking on this check box affects the way that children items are displayed on the template. Click on this check box if you want to allow only one of the subordinate items to be selectable. Clicking on this check box changes the check boxes into radio buttons so that only one item can be selected at a time. To deselect all items, click on the one that is selected and the radio button will be cleared.

Hide Dialog Items

Clicking on this check box affects the way that children items are displayed on the template. Click on this option to have subordinate items appear only if the parent item is selected. This feature allows for custom user input. The user only sees the options related to the items selected. This feature requires boilerplated text at the parent level.

Allow Long Lines

A check box in the Template Editor named “Allow Long Lines” allows template lines to be up to 240 characters in length. This feature mainly accommodates template field markup.

Types of Templates

When you create templates, you can go directly into the Template Editor. There, you can type in text, and add Template Fields. If you are in a document and type in something you will use repeatedly, you simply select that text, right-click, select Create New Template, and the editor comes up with the selected text in the editing area. You can create individual templates, group templates, dialog templates, folders, or link templates to Reminder dialogs. Template dialogs are resizable.

Templates

Templates contain text, TIU objects, and Template Fields that you can place in a document.

Group Templates

Group templates contain text and TIU objects and can also contain other templates. If you place a group template in a document, all text and objects in the group template and all the templates it contains (unless they are excluded from the group template) will be placed in the document. You can also expand the view of the group template and place the individual templates it contains in a document one at a time.

Dialog Templates

Dialog templates are like group templates in that they contain other templates. You can place a number of other templates under a dialog template. Then, when you drag the dialog template into your document, a dialog appears that has a checkbox for each template under the Dialog template. The person writing the document can check the items they want and click OK to place them in the note.

Folders

Folders are like folders or directories in a file system. They are used to group and organize templates. It is there to hold templates and help in navigating the template tree view. For example, you might create a folder called "radiology" for templates, group templates, and other folders relating to radiology.

Reminder Dialog

Reminder dialogs can have template linked to them. This allows templates to place orders, enter PCE information, and enter vitals and mental health data. Refer to Creating Reminder Dialogs for this procedure.

Arranging Templates for Ease of Use

How you arrange your templates will depend on what your specific needs are. However, it may be useful to group similar templates together. You can also use folders to group similar templates, making them easier to find. This organization will be similar to a good directory structure for your workstation. For example, you may want to place all of the pulmonary templates together rather than alphabetizing templates.

By grouping the templates that you use, you will spend less time moving around the tree view to find the template that you need.

Using Templates to Create Documents

Once you or your clinical coordinator has created templates, adding them to a document is easy. When you create a new Note, the Templates drawer appears. When you click the drawer, it opens to show you the templates that are available.

Group templates, dialogs, and folders may have a plus next to them. Click the plus to expand the tree view and see the templates they contain. Click a minus sign to collapse the tree view, hiding the templates under that item.

When you find the template you want to place in a document, you can drag-and-drop it into the document, double-click it, or right-click and choose Insert Template. The text and objects will appear at the cursor location in the document.

Searching for Templates

You can search for templates by the words in the template name. To search:

1. Right-click in the tree view (either in the Template Editor or in the Templates drawer).
2. Select the appropriate option: Find Templates; Find Personal Templates; or Find Shared Templates (depending on which tree view you are in)

   Note: You may want to narrow your search by using the *Find Options*.
3. A text field, Find button, and two find options check boxes will appear. Enter the word or words you want to find.
4. Click Find.
5. If the first occurrence is not the one you desire, scan the list or click Find Next.
6. Repeat step 5 until you find the desired template.

Previewing a Template

You can preview a template to see what it will place in your document. To preview a template, right-click on it in the Templates drawer on the Notes tab. Then select Preview/Print Template. The dialog also has a Print button, which allows you to produce a hard copy of the template.

Deleting Document Templates

When you no longer need a template or if you create one by mistake, you can delete it. CPRS will ask you if you want to make the template inactive rather than delete it. To delete a document template, use these steps:

1. Click the **Notes**, **Consults**, or **D/C Summ tab**.
2. Select **Options | Edit Templates** or if the Templates drawer is open, right-click in the drawer, and select **Edit Templates**.
3. Find the template you want to delete. Click the plus sign next to an item to see the objects under it. Continue until you find the right location.
4. Right-click the template you want to delete and select Delete or click the template you want to delete and then click the **Delete** button under that tree view.

5. Click **Yes** to confirm the deletion.

Creating Personal Document Templates

You can create personal templates consisting of text, Template Fields, and Patient Data Objects to speed document creation. You can use the templates to create progress notes, complete consults, and write discharge summaries.

Personal Template

To create a personal document template, use these steps:

1. On the Notes, Consults, or D/C Summ tab, bring up the Template Editor by selecting **Options | Create New Template…**
   or
   to save specific text from a document in CPRS as a template, select the text, right-click on it, and select **Copy into New Template**.
2. In the Name field under Personal Template Properties, type in a name for the new template.

   Note: Template names must begin with a letter or a number, be between 3 and 30 characters in length (including spaces), and cannot be named "New Template."

3. Click on the drop down button in the Template Type field and select **Template**.
4. Enter the content for the template by copying and pasting from documents outside CPRS, typing in text, and/or inserting Template Fields.

   Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or check for errors (which looks for invalid Template Fields).
5. Place the template where you want it in the tree view. To place it, click the plus sign next to an item to see the objects under it. Then, drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)
6. To save the template, click **Apply**. To save and exit the editor, click **OK**.

   Note: You are not required to click Apply after each template, but it is recommended. If you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Group Template

You can create group templates that contain other templates under them. You can then place the entire group template in the note, which will bring in the text and Template Fields from all templates in that group, or expand the tree view in the Templates drawer and place the individual templates under the group template in the note.

To create a personal Group Template, use these steps:

1. On the Notes, Consults, or D/C Summ tab, bring up the Template Editor by selecting **Options | Create New Template** or you may save specific text from a document in CPRS as a template, select the text, right-click on it, and then select Copy into New Template.

2. In the Name field under Personal Template Properties, enter a name for the new template. Remember the template name requirements. You should also make the name descriptive of the content for ease of use.
3. Click on the drop-down button in the Template Type field and select Group Template.
4. If desired, enter the text and Template Fields to create content in the main text area of the group template. You can enter content by copying and pasting from documents outside CPRS, typing in text, and/or inserting Template Fields.

   Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or Check Boilerplate for Errors, which looks for invalid Template Fields .
5. You can also create additional templates under the Group Template that you just created and add content there. You can do that by highlighting the appropriate group template and clicking New Template. Then complete the steps for creating a new template as they are outlined above.
6. Place the template where you want it in the tree view. Click the plus sign next to an item to see the objects under it. Then drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)
7. To save the template, click **Apply**. To save and exit the editor, click **OK**.

   Note: You are not required to click Apply after each template, but it is recommended. If you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Associating a Template with a Document Title, Consult, or Procedure

Clinical Coordinators and others who are authorized to edit shared templates and who are also members of the appropriate user class (specified in the EDITOR CLASS field, #.07 of the TIU TEMPLATE file #8927) may see the Document Titles, Consult Reasons for Request, and/or the Procedure Reasons for Request template folders. These folders allow you to associate a template with a progress note title, a procedure, or a type of consult. After an association is created, the appropriate template content is inserted in either the body of a note (when a new note is started) or in the Reason for Request field (when a new consult or procedure is ordered).

To associate a template with a document title, type of consult, or a procedure, follow these steps:

1. Create a new template (by following the instructions above for either the personal template or the group template)
   -or-
   edit an existing template by selecting Options | Edit Templates….from the Notes, Consults, or D/C Summ tab
2. Click the Edit Shared Templates checkbox located in the lower-left corner of the Template Editor window.
3. Select the template you would like to associate from the Personal Templates section of the Template Editor window.

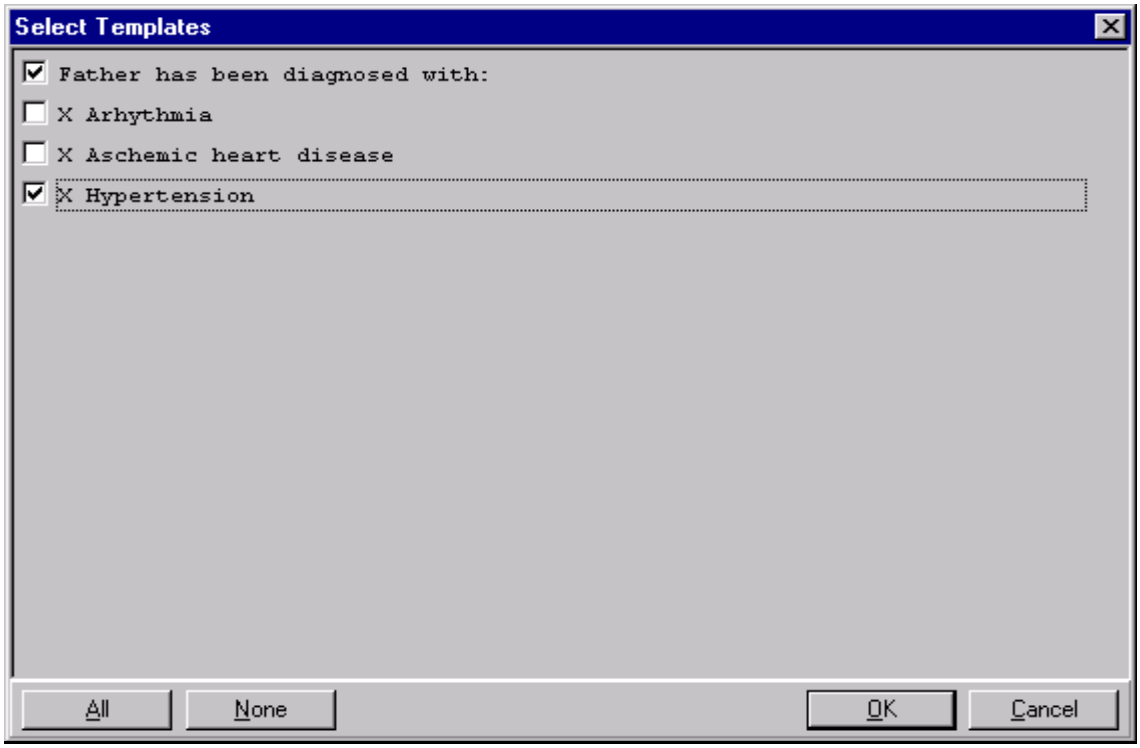
4. Drag and drop the template into either the Document Titles, Consult Reasons for Request or Procedure Reasons for Request folder in the Shared Templates area of the window.
5. In the Shared Templates area of the window, select the template that you just moved (click "+" to expand a heading).
6. Select a procedure from the Associated Procedure drop down list
   -or-
   select a consult service from the Associated Consult Service drop down list.
7. Click OK.
   The template is now associated. When you order a consult or a procedure, the associated template text will appear in the Reason for Request field. When you enter a new progress note the associated template text will appear in the text of the note.

Dialog Template

Dialog templates contain other templates just as group templates do. Unless there is only one template, each template under a dialog template will have a check box in a dialog when the template is placed in a document. A single template under a dialog template will not have a check box. Pressing the OK button will insert the dialog element into the note.

When a user double-clicks a dialog template or drags it onto the note, a dialog appears. The dialog shows the text for each template preceded by a check box.

The user clicks the box to check which items will be included in the note. The user can click All to select all of the elements. The user may click None to begin again. The user clicks OK when selection is complete.



To create a personal Dialog Template, complete these steps:

1. On the Notes, Consults, or D/C Summary tab, bring up the Template Editor by selecting **Options | Create New Template** or you may save specific text from a document in CPRS as a template, by selecting the text, right-clicking on it, and selecting Copy into New Template.
2. In the Name field under Personal Template Properties, enter a name for the new template. Remember the template name requirements. You should also make the name descriptive of the content for ease of use.
3. Click on the drop-down button in the Template Type field and select Dialog.
4. If desired, enter the text and Template Fields to create content in the main text area of the template. You can enter content by copying and pasting from documents outside CPRS, typing in text, and/or inserting Template Fields.

   Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or Check Boilerplate for Errors, which looks for invalid Template Fields.
5. You can also create additional templates under the dialog template that you just created and add content there by highlighting the appropriate dialog template and clicking New Template. Then complete the steps for creating a new template as they are outlined above.
6. Place the template where you want it in the tree view. Click the plus sign next to an item to see the objects under it. Then, drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)
7. To save the template, click Apply. To save and exit the editor, click OK.

   Note: You are not required to click Apply after each template, but it is recommended. If you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Reminder Dialog

Templates can be linked to Reminder dialogs. This allows templates to place orders, enter PCE information, and enter vitals and mental health data.

To create a Reminder Dialog, follow these steps:

1. On the Notes, Consults, or D/C Summ tab, bring up the Template Editor by selecting Options | Create New Template…
2. In the *Name* field under Personal Template Properties, type in a name for the new template. Remember the template name requirements. You should also make the name descriptive of the content for ease of use.
3. Click on the drop down button in the Template Type field and select Reminder Dialog.
4. Click on the drop-down button in the Dialog field and select the Reminder Dialog desired.
5. Place the template where you want it in the tree view by clicking the plus sign next to an item to see the objects under it. Then drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)
6. To save the template, click Apply. To save and exit the editor, click OK.

Note: You do not have to click Apply after each template, but it is recommended because if you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Only Reminder Dialogs that are listed in the TIU Reminder Dialogs parameter can be linked to templates. If there are no Reminder Dialogs in this parameter, the Reminder Dialog template type will not be available.

Folder

Folders are simply containers that allow you to organize and categorize your templates. For example, you might want to create a folder for templates about diabetes or one about mental health issues.

To create a personal template folder, complete these steps:

1. On the Notes, Consults, or D/C Summ tab, open the Template Editor by selecting **Options | Create New Template** or you may save specific text from a document in CPRS as a template, select the text, right-click on it, and select Copy into New Template.
2. In the Name field under Personal Template Properties, enter a name for the new folder. You should also make the name descriptive of the content for ease of use.
3. Click the template type: Folder.
4. Click and drag the templates that relate to the folder you created.

   Note: You do not have to click Apply after each template, but it is recommended because if you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

View Template Notes

Template Notes can be used to describe what is in the template or to track changes to the template.

To add or display Template Notes:

1. From the Notes tab, click on Options | Edit Templates...
2. Select the shared or personal template for which you wish to add or change the Template Notes.
3. Click on the Show Template Notes check box at the bottom of the dialog. The *Template Notes* field appears below the *Template Boilerplate* field.
4. Add or change the note as much as you wish.

   Note: If the template you wish to edit is a shared template and you have the authority, you will need to click on the Edit Shared Templates check box on the lower left corner of the Template Editor dialog.
5. To add or display Template Notes from the Template Drawer:
6. From the Template Editor, select the shared or personal template for which you wish to add or change the Template Notes.
7. Click on the Show Template Notes check box at the bottom of the dialog. The *Template Notes* field appears below the *Template Boilerplate* field.

   Add or change the note as much as you wish.

Note: If the template you wish to edit is a shared template and you have the authority, you will need to click on the Edit Shared Templates check box on the lower left corner of the Template Editor dialog.

Copying Template Text

To copy text from a template to any text field:

1. Open a new note, consult or discharge summary.
2. Select a note, consult or discharge surgery title.
3. Click on the Notes tab
4. Click on the Templates drawer button.
5. Expand either the Shared Template or Personal Templates tree.
6. Right click on the desired template.
7. Click Copy Template Text (or press Control+C) to simply copy the text to the clipboard.

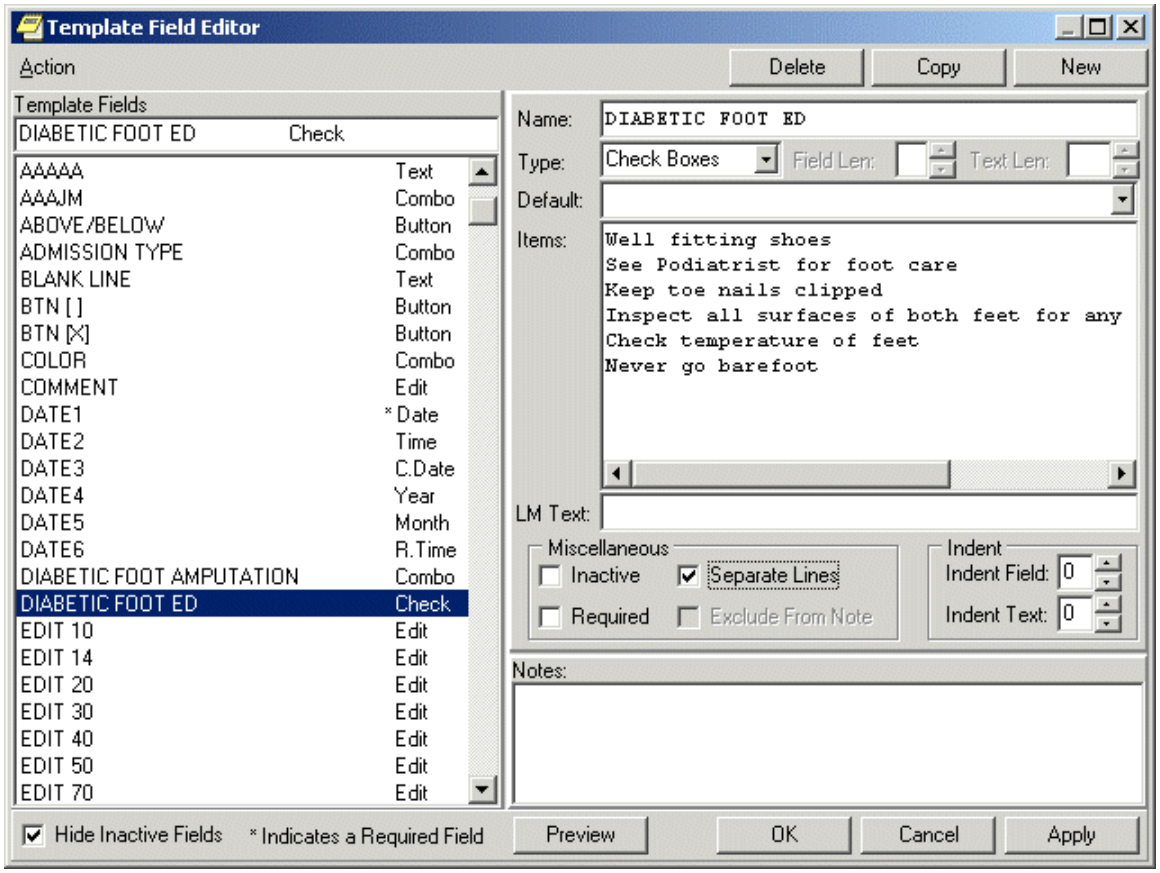
With the template text copied to the Clipboard, you may switch to any text field in CPRS and place the template text by right clicking in the desired field and selecting Paste.

Template Fields

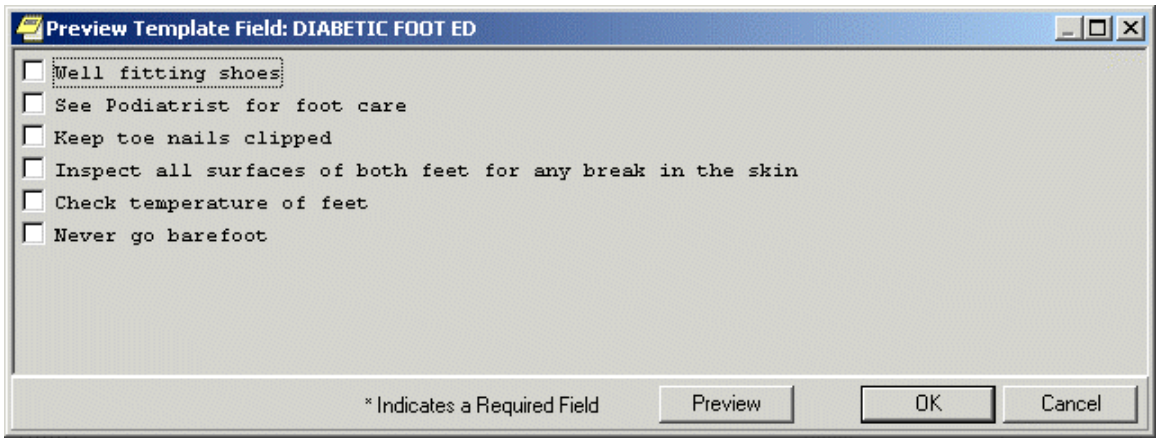
Template fields allow you to create text edit boxes and to create lists of text that can be selected via combo boxes, buttons, check boxes, or radio buttons. These controls can be added to templates, boiler plated titles, boiler plated reasons for request, and reminder dialogs, through a new type of markup syntax {FLD:TemplateFieldName}. A Template field editor has also been added that can be used by members of the ASU user classes listed in the new TIU FIELD EDITOR CLASSES parameter. The template field editor can be accessed through the options menu on Notes, Consults and D/C Summaries tabs, as well as through the new Template Editor Tools menu. There is also a new Insert Template Field menu option in the Template Editor, following the Insert Patient Data Object menu option. Free text can be entered into Template Field Combo boxes.

Template Dialogs will now show an asterisk (*) before required template fields, and will not allow you to press the OK button if there are required fields that have not been completed. A message has also been added at the bottom of the template dialogs that states "* Indicates a Required Field".

Template Fields can also be used in boilerplated text that can be associated to a new Note, Consult, or Discharge Summary.



When you click the Preview button, you can view how the template dialog will appear. Note that since the Separate Lines check box is enable on the Template field Editor dialog, the check box items on the preview are each listed on a separate line. These fields can optionally be marked as Required. Template Field Preview forms are resizable.



Using the Template Field Editor

Adding template fields to your templates and dialogs can reduce the time required to complete a note, consult or discharge summary. By including template fields in your template, information that would normally need to be looked up, can be pulled directly into the note, consult or discharge summary.

To view the predefined characteristics of the template fields:

1. Click on either the Notes, Consults, or D/C Summ tab.

2. Select **Options** | **Edit Templates**.
   Click on the desired template field in the Template Fields list on the left side of the dialog. The field is copied to the Name field on the right side of the dialog and all of the existing elements of the field are displayed.
3. Click Preview to see how the Template Field will appear on a template or click OK to complete the procedure.
4. To create a new template field:
5. Click on either the Notes, Consults, or D/C Summ tab.
6. Select Options | Edit Templates.
7. Click New Template in the upper right corner of the Template Field Editor dialog.
8. Type a unique name for the new template field.
9. Select a Type. If Edit Box is selected, type or select a number between 1 and 70 into the Maximum Number of Characters field. If Combo Box, Button, Check Boxes or Radio Buttons are selected as the Type, the Default field and Maximum Number of Characters fields are unavailable. The Items field and the Default field below Items are active.
10. The Default field below the Type field is available only when Edit Box is the Type selected. Type the text that you wish to have appears in the Edit Box by default. On the template, the user can accept the default text or change it, as long as the new text is within the Maximum Number of Characters limit.
11. If the Type is Combo Box, Button, Check Boxes, or Radio Buttons, the Items field will be active. Type the different choices from which you wish to let the user choose. Each item must be on a separate line in the Items field. However, if you wish to have the Items listed on separate lines in the template, you must enable the Separate Lines check box.
12. If the Type is Combo Box, Button, Check Boxes, or Radio Buttons, the second Default field will be active. If you wish, you may click the drop-down button and select one of the items as the default.
13. If you wish, you may type text in the LM Text field and it will appear in the List Manager version. Template Fields have been developed strictly for GUI functionality. If you are still using LM, the text {FLD:TEMPLATE FIELD NAME} will appear in LM body of the note. To avoid this, type text in this field.
14. If the field being created on the template is required, enable the Required check box, which will prevent the template from being closed without the field being selected or completed.
15. You may include text in the Notes field that will explain or describe the Template Field. You may also use it to record changes that have been made to the Template field. The text typed into this field will not appear on the template. These notes will not appear to a user when entering a note. They are for development use only as notes to the creator.
16. Click Preview to see how the Template Field will appear on a template or click OK to complete the procedure.

Inserting Template Fields into a Template

Once you have decided which Template fields to use or you have defined the Template Field that you need, you can add them into a template. With the Template field in the Template, you can quickly and easily select the items you wish to add to a note, consult or discharge summary.

To add a Template Field into a Template:

1. From the Notes, Consults or D/C Summ tab, click Options | Edit Templates... or Create Templates, Edit Shared Templates, or Create New Shared Template...
2. From the Template Editor, select the template to which you wish to add a Template Field.
3. Insert the cursor at the place in the Template Boilerplate field where you wish to insert the Template Field.
4. From the toolbar, click Edit | Insert Template Field or right-click in the template and select Insert Template Field.
5. On the Insert Template Field dialog, type the first few letters of the desired field or scroll through the list until the desired field is located.
6. Click on the field you wish to insert.
7. Click Insert Field.
8. Repeat steps 5 through 7 for each additional Template Field you wish to insert.
9. Click Done when you have added all of the desired template fields.
10. From the tool bar, click Edit | Preview/Print Template or right-click in the template and select Preview/Print Template. This will preview the template. If the template does not display with the desired appearance, you may continue to edit it.
11. On the Template Editor dialog, click OK to save the changes to the template.
    Note: The Insert Template Field dialog is non-modal and can be boilerplated at will.

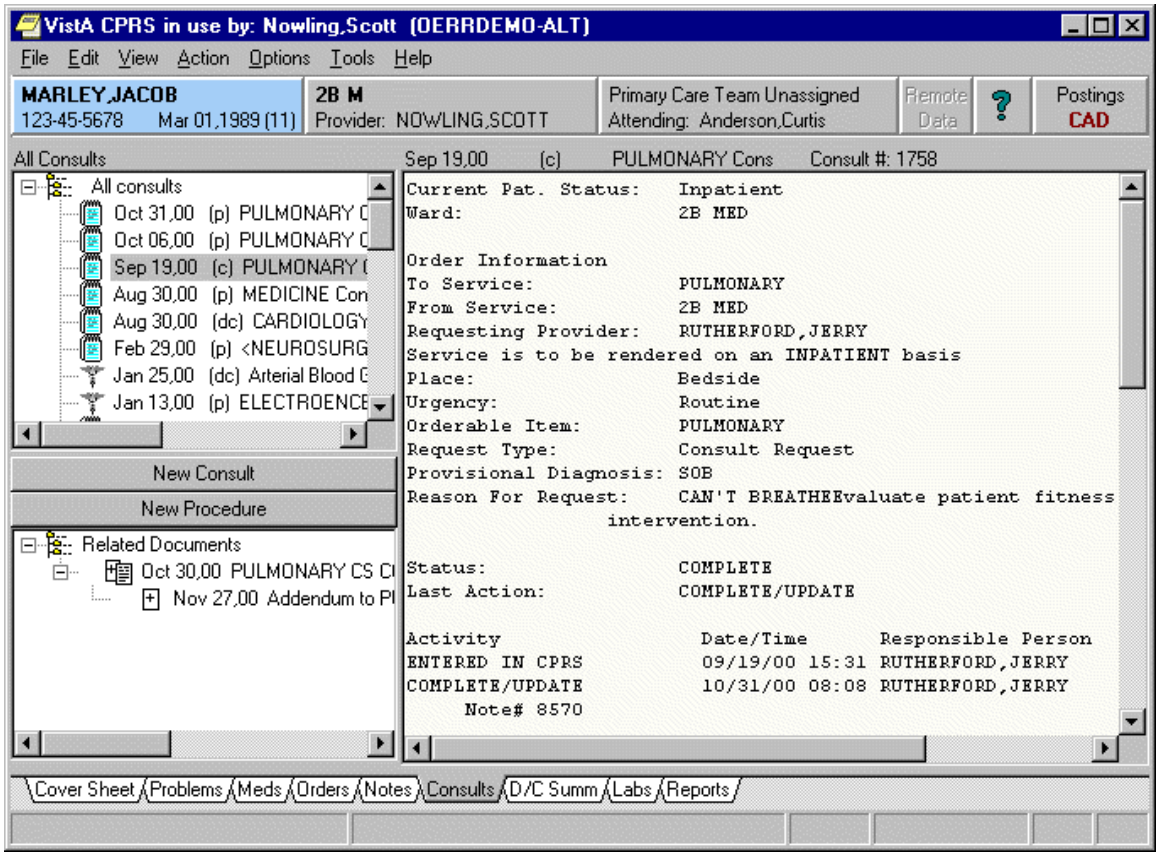
Consults

Consults are requests from one clinician to a hospital, service or specialty for a procedure or other service.

The Consults process involves the following steps. A single individual or service does not take all of the steps.

1. The clinician orders a consult. From within the patient's CPRS medical record, the clinician enters an order for a consultation or procedure. The ordering clinician may first have to enter Encounter Information.
2. The consult service receives an alert and a printed SF 513. The receiving service can then accept the consult, forward it to another service, or send it back to the originating clinician for more information.
3. The consult service accepts or rejects the consult request. To accept the consult, the service uses the receive action. The service can also discontinue or cancel the consult. Cancelled consults can be edited and resubmitted by the ordering clinician. A consult service clinician sees the patient.

   The consult service enters results and comments. Resulting is primarily handled through TIU.
4. The originating clinician receives a CONSULT/REQUEST UPDATED alert that the consult is complete. The results can now be examined and further action taken on behalf of the patient.
5. The SF 513 report becomes part of the patient's medical record. A hard copy can be filed and the electronic copy is on line for paperless access.
6. Results from the Medicine package can be attached to complete consults involving procedures. This function is available through the GUI for the Consults package, but will only be seen when the supporting Consults patch GMRC*3.0*15 is installed. The absence of these patches will result only in the function not being present.
7. If Consults patch GMRC*3.0*18 has been installed, the Edit/Resubmit action is available for cancelled consults. The consult must be "resubmittable" and the user must be authorized to resubmit consults.
8. The Consults tab has a list of consults in a tree view similar to the ones found on the Notes tab and the Discharge Summary tab. However, the list view feature is not available due to differences in the tabs functions. Consults are differentiated from procedures in the tree by the type of icon displayed. Consults are represented by a notepad, while procedures are represented by a caduceus-like symbol.
9. Right-click in the Consults text and you may select the "Find in Selected Consult" option from the popup menu. This option allows you to search the displayed text. A "Replace Text" option is also available, but it is only active when a consult is being edited.
10. The field below the list of consults displays a list of documents related to the highlighted consult or procedure. These related documents are also in a tree view.



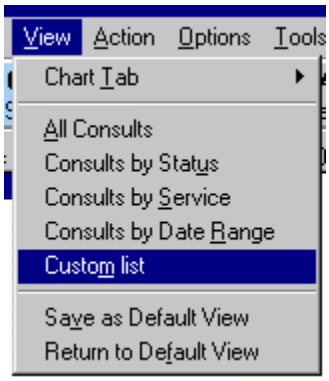
Changing the View on the Consults tab

Changing the view of the Consults tab allows you to focus the list of consults on one of several criteria. Focusing the list will speed up the selection process.

You may change the Consults view to only include the following problems:

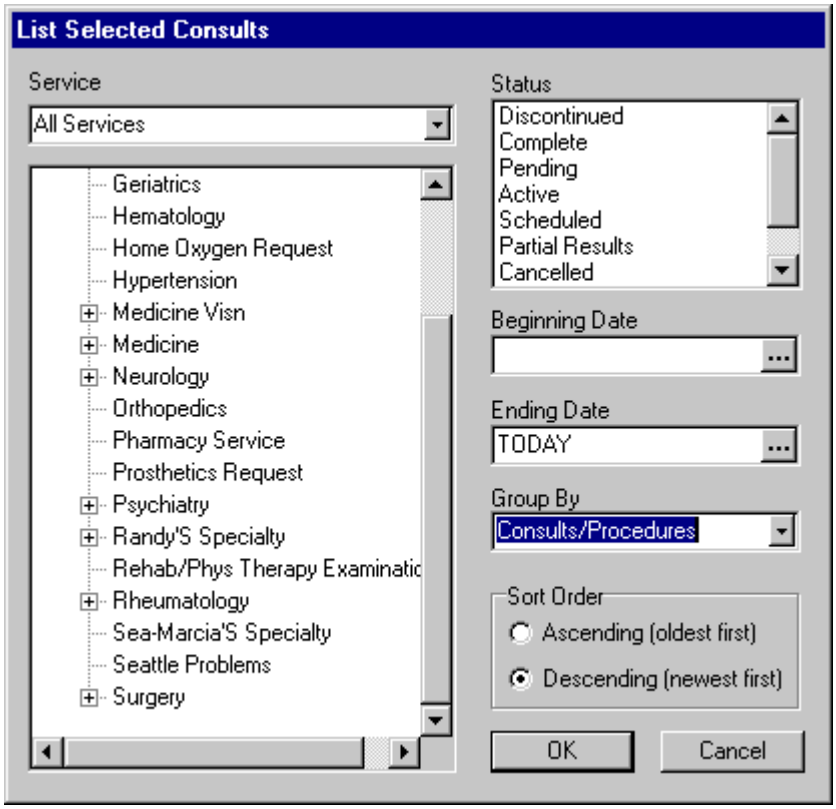
- All Consults
- Consults by Status
- Consults by Service
- Consults by Date Range

To change the view, click on View on the menu and select the desired list items.

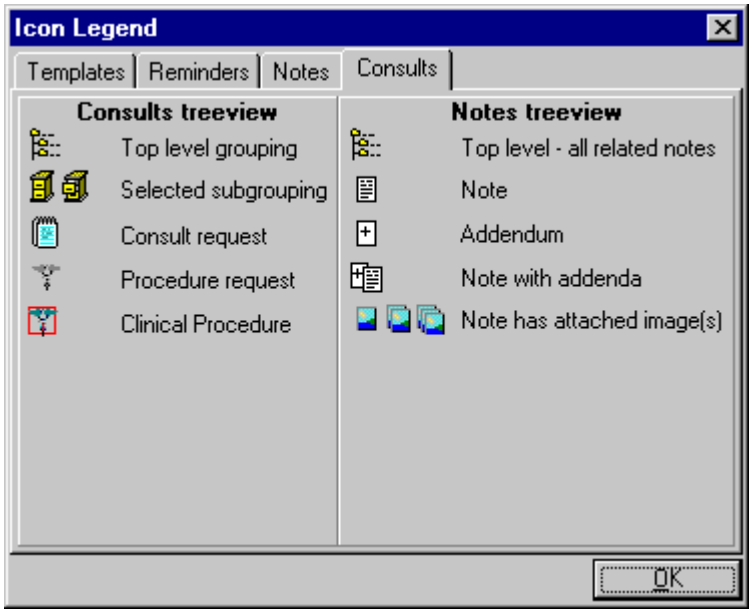


You may select the Custom list option on the menu to further focus the list of notes you wish to have displayed. From the List Selected Consults dialog, you may choose to display

consults by any combination of service, status, and date range. You can also group your results by consults versus procedures, by service, or by status.



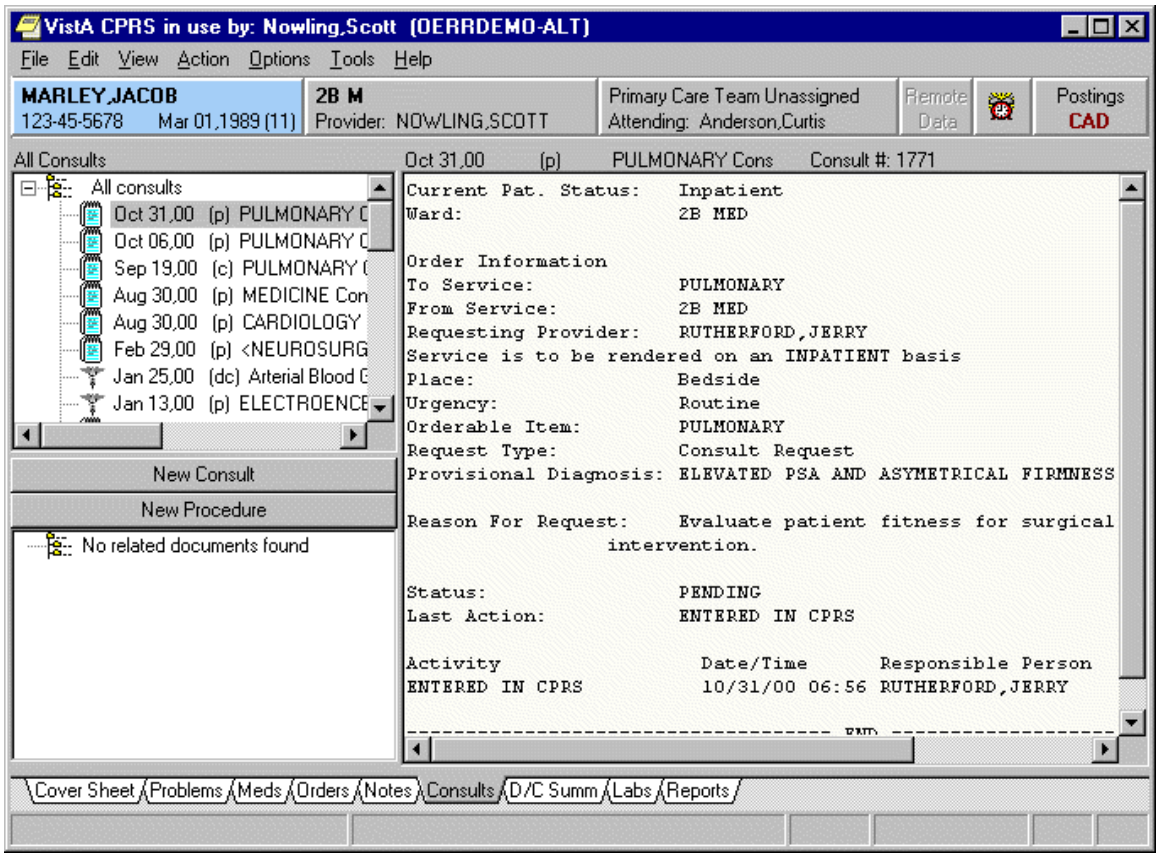
The Consults tab on the Icon Legends dialog includes a description and explanation of the different icons that appear on the Consults tree view. To access the Icon Legend, click View | Icon Legend and the click on the Consults tab.



Ordering Consults

You can order a consult or procedure from either the Consults or the Orders tab. As you fill in the options, the consult request will be displayed in the text box at the bottom center of the dialog.

The list of Consults has been changed to a tree view. Consults are distinguished from procedures in the tree by the icon displayed in the tree. Consults are represented by a notepad, while procedures are represented by a caduceus-like symbol.



Viewing Consults

To view the consults or procedures for the selected patient, use the steps below. When you select a specific consult, you will see an area that lists any notes associated with the consult. You can also click on a note entry to view the full text of the note.

The All Consults list box shows the date, status (p=pending, c=complete, dc=discontinued, and x=cancelled), and title of each consult. An asterisk preceding the title tells you that there are significant findings for that consult.

To view consults, follow these steps:

1. Click the **Consults** tab.
2. Locate the entry in the All Consults list box for the consult you want to view. You may need to scroll though the list.

   Note: To see the full entry line, you can either resize the pane containing the All Consults list or place the mouse pointer over an entry and leave it there to make CPRS display the entire entry line.

3. Click the entry of the consult you want to view.

The consult will then be displayed in the main text box.

Complete a Consult from the Consults tab

To complete a consult from the Consults tab, complete the following steps:

1. Click the **Consults** tab.
2. Click on **Action | Consult Results | Complete/Update Results**.

   Note: If this visit is undefined, you will be prompted for encounter type and location, clinician, date, and type of visit, such as Ambulatory, Telephone, or Historical.
3. In the Progress Note Properties dialog, select Progress Note Title (e.g., General, SOAP, Warning, etc.). Additional items will appear on the dialog for titles that require entry of a cosigner or an associated consult.
4. If necessary, change the note date by clicking the button next to the date and entering a new date.
5. If necessary, change the note author by selecting the author from the Author drop-down list.
6. Enter any additional information, such as an associated consult or expected cosigner. Completing these steps will allow the note to be automatically saved.
7. Click **OK**.
8. Create your note by typing text, using templates, and including any test results.

From the Action menu, select either **Sign Note Now** or **Save without Signature**.

Creating a New Consult from the Consults tab

To create a new consult from the Consults tab, complete the following steps:

1. Click the **Consults** tab.
2. Click the **New Consult** button.
3. If the Provider and Location for Current Activities dialog opens, fill in the Visit Location and other information and click **OK**.
4. Select a service from in the Consult to Service/Specialty window.
5. Fill in a Reason for Consult.
6. Make sure the following have the correct value:
   - Service to perform this procedure
   - Service rendered on
   - Urgency
   - Place of Consultation
   - Attention
   - Provisional Diagnosis

7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click **Quit**.

You may sign the consult now or later.

Requesting a New Procedure from the Consults tab

To request a new consult from the Consults tab, complete the following steps:

1. Select the **Consults** Tab.
2. Click the **New Procedure** button.
3. If the Provider & Location for Current Activities dialog opens, fill in contact information, and click **OK**.
4. Select a procedure.
5. Fill in a Reason for Consult.
6. Make sure the following fields show the correct information:
    - Service to perform this procedure
    - Service rendered on
    - Urgency
    - Place of Consultation
    - Attention
    - Provisional Diagnosis
7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click **Quit**.
9. You may sign the consult now or later.

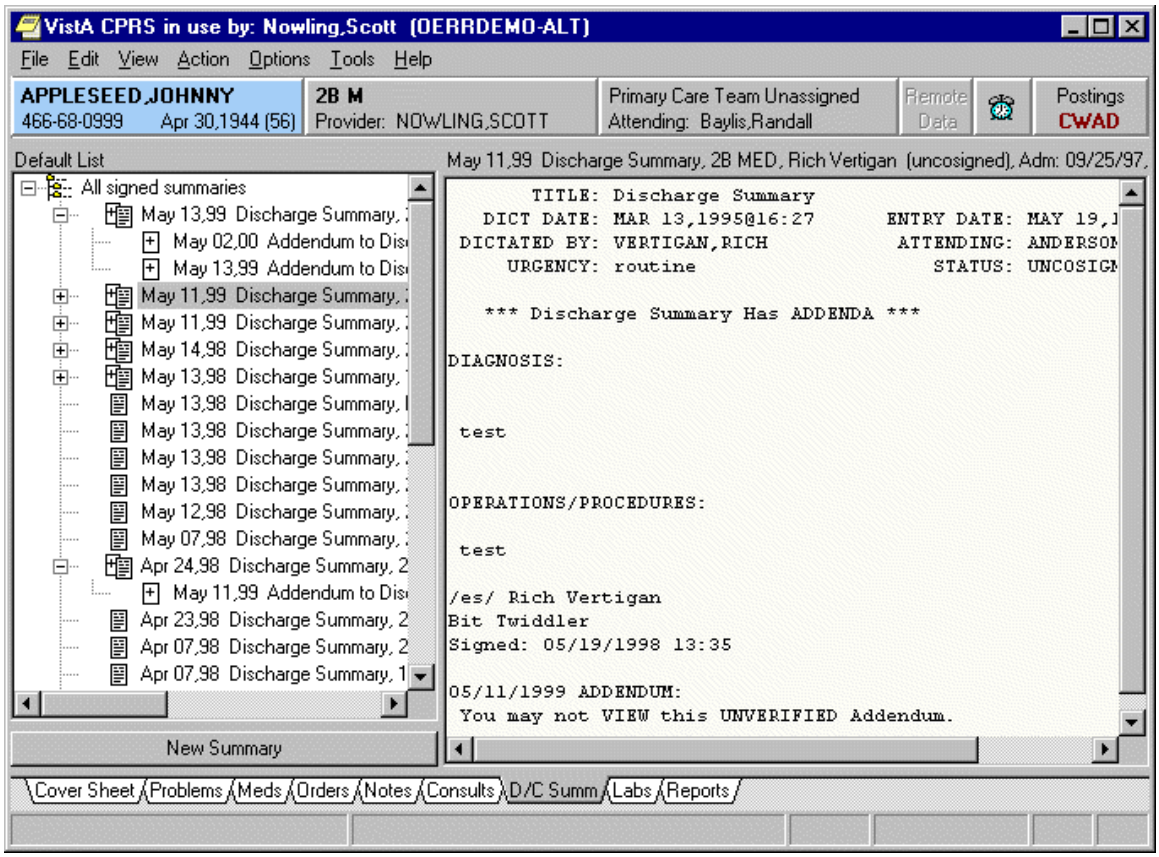
Discharge Summary

Discharge Orders are sets of orders to be placed for a patient when checking out of the hospital. The Discharge Summary tab gives you quick access to the Discharge Summary for a specific patient. The list of documents in the D/C Summ tab is in a tree structure instead of a simple list. Highlight any discharge summary listed in the left field to view the text of the summary in the right field. Addenda are separately selectable and are displayed as a page with a plus sign behind a note page (See highlight below.) Discharge Summaries with Addenda have a clickable plus sign. Hold the mouse pointer over a listing to see the entire line of the listing. The Discharge Summary that is highlighted is displayed on the right.

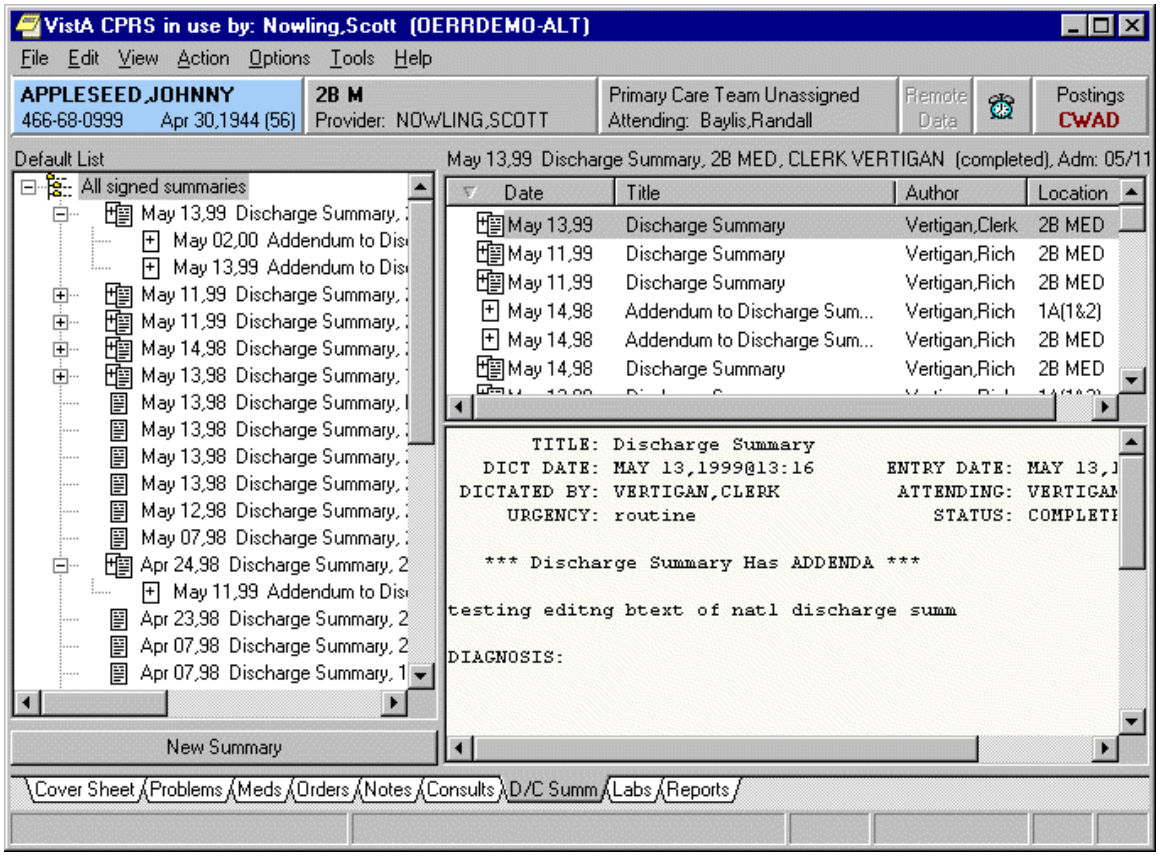
Right-click in the Discharge Summary text and you may select the “Find in Selected Summary” option from the popup menu. This option allows you to search the displayed text. A “Replace Text” option is also available, but it is only active when a discharge summary is being edited.

Click on the View and Action menus to see the available options. Double click the plus sign to expand the list. Once expanded, any discharge summary may be selected and viewed.

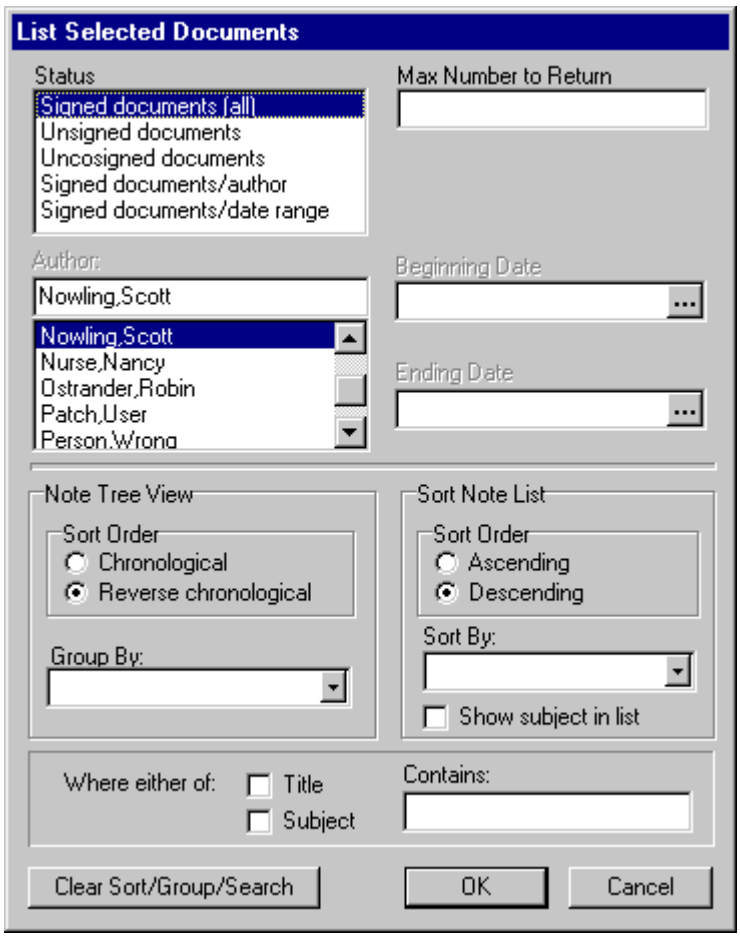
You can also click the New Summary button to create a Discharge Summary. You may also have to enter encounter information if the visit has not been defined.



Select a grouping node (for example "All signed notes") in the tree to display a second list of all the documents falling under that grouping node. This second list can be sorted by clicking on the column headings (Date, Title, Author, Location).



The Custom View dialog (**View | Custom View**) has been greatly expanded, allowing the items in the tree to be grouped and sorted in a variety of ways. All custom view selections can be saved as the user's default view (**View | Save as Default View**).



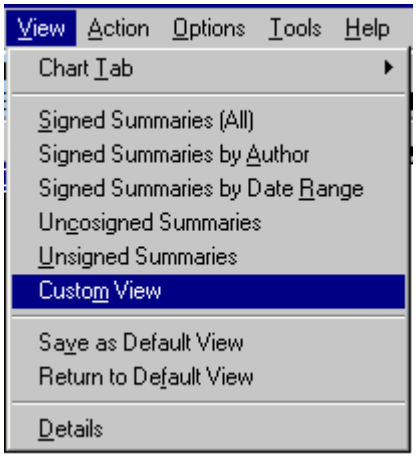
Changing Views on the Discharge Summaries tab

Changing the view of the Discharge Summary tab allows you to focus the list of summaries on one of several criteria. Focusing the list will speed up the selection process.

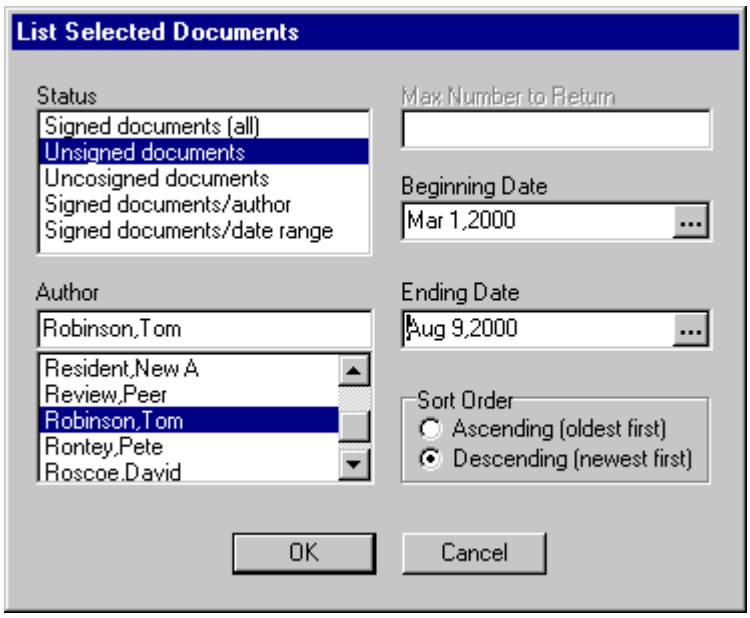
You may change the Discharge Summaries List view to only include the following summaries:

- Signed Summaries (All)
- Signed Summaries by Author
- Signed Summaries by Date Range
- Uncosigned Summaries
- Unsigned Summaries

To change the view, click on View on the menu and select the desired list items.



You may select the Custom View option on the menu to further focus the list of summaries you wish to have displayed. From the List Selected Documents dialog, you may choose to display summaries by any combination of Status, Author, and date range.



To view a discharge summary, use these steps:

1. Click the **D/C Summ** tab.
2. Click on the summary in the list box.
3. To sort the list, select View and the appropriate choice below:
    - Signed Summaries (All)
    - Signed Summaries by Author
    - Signed Summaries by Date Range
    - Uncosigned Summaries
    - Unsigned Summaries
    - Custom View

    Note: To set one of these views as the default, select View | Save as Default.
4. Locate the summary and click on it.

Writing Discharge Summaries

You can enter discharge summaries through CPRS. The document templates and TIU titles that your site can create should make creating these documents much faster and easier.

To write a discharge summary, use these steps:

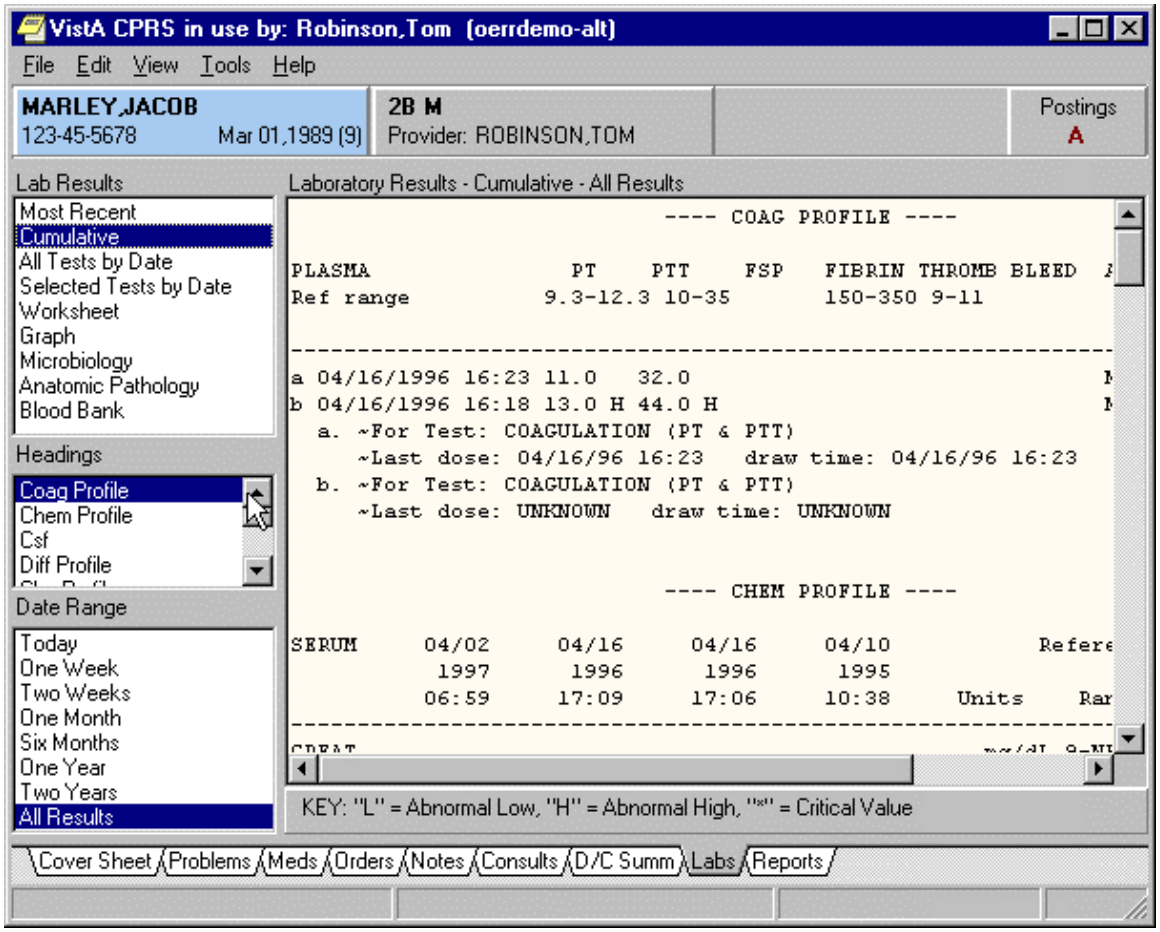
1. Click the **D/C Summ** tab.
2. Click New Summary or select **Action | New Discharge Summary**.

   Note: If this visit is undefined, you will prompted for encounter type and location, clinician, date, and type of visit, such as Ambulatory, Telephone, or Historical.
3. In the Discharge Summary Properties dialog, select Discharge Summary Title (e.g., General, SOAP, Warning, etc.). Additional items will appear on the dialog for titles that require entry of a cosigner or an associated consult.
4. If necessary, change the note date by clicking the button next to the date and entering a new date.
5. If necessary, change the note author by selecting the author from the Author drop-down list.
6. Enter the attending physician.
7. Click the admission related to this Discharge Summary.
8. Enter any additional information, such as an expected cosigner. Completing these steps will allow the note to be automatically saved.
9. Click **OK**.
10. Create the summary content by typing in text, copying and pasting, and/or inserting templates into the document.
11. Click the template drawer if it is not open.
12. Locate the appropriate templates.
13. Double-click the template (You can also drag-and-drop or right-click the template and select Insert Template) and modify as needed.
14. When finished entering text, you may (optional) right-click in the text area and select Check Spelling and Check Grammar.
15. When complete, decide when you will sign the summary and choose the appropriate option:

16 Click **Add to Signature List** (to place it with other orders or documents you need to sign for this patient). You can also click on Save Without Signature or Sign Discharge Summary Now to sign the summary immediately.

Labs

On the Labs tab, you can view the results of lab tests that were ordered for a selected patient. Ordering of lab tests is performed on the Orders tab. The Cover Sheet tab displays results of some of the patient's most recent orders. Some of the lab reports are also found on the Reports tab. The fields on the left side of the Labs tab list available lab results. For some reports, you may need to specify a date range or other criteria. Some reports will prompt for specific tests to be displayed.



Viewing Laboratory Test Results

Through CPRS, you can review lab test results in many formats.

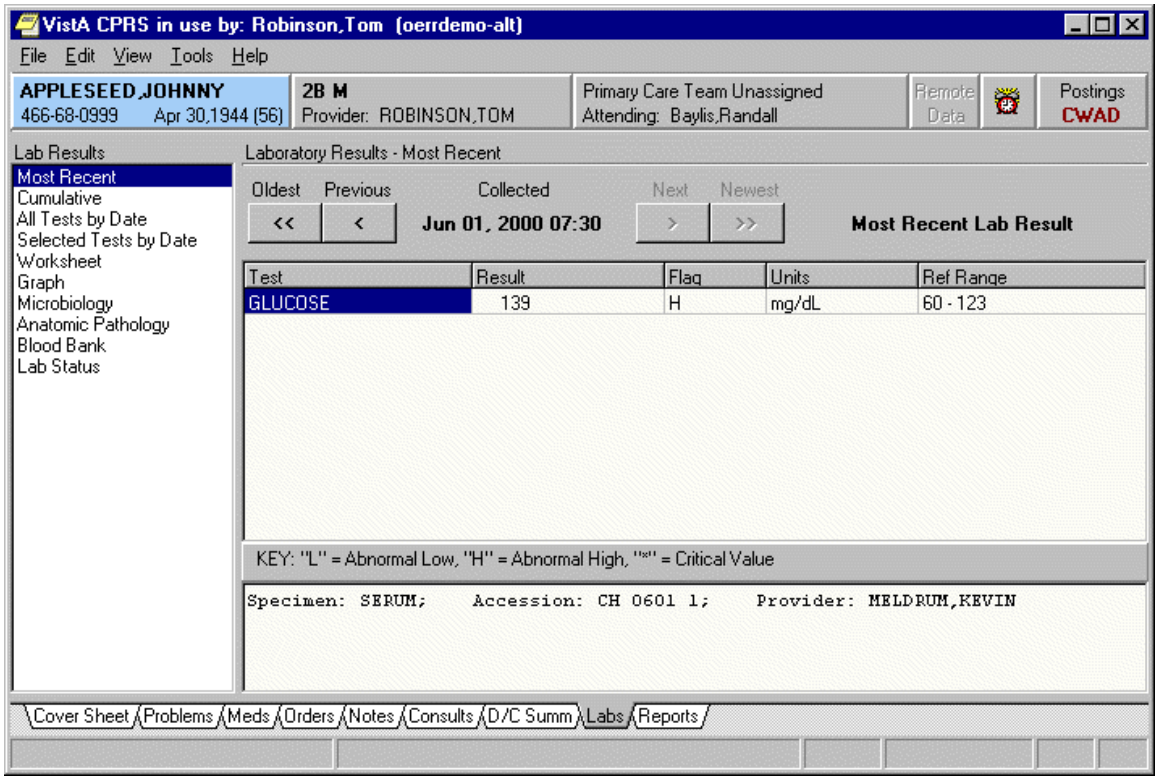
To view lab test results, use these steps:

1. Click the **Labs** tab.
2. In the Lab Results box, click the type of results you want to see. Some of the results will need you to determine which test results you want to see. If the Select Lab Test dialog appears, you need to choose the tests you want to see.

   Note: A plus sign (+) by a lab test means it has a schedule.
3. If necessary, select the tests for which you want to see the results.
4. Also, you may need to choose a date range (Today, One Week, Two Weeks, One Month, Six Months, One Year, Two Years, or All Results.)

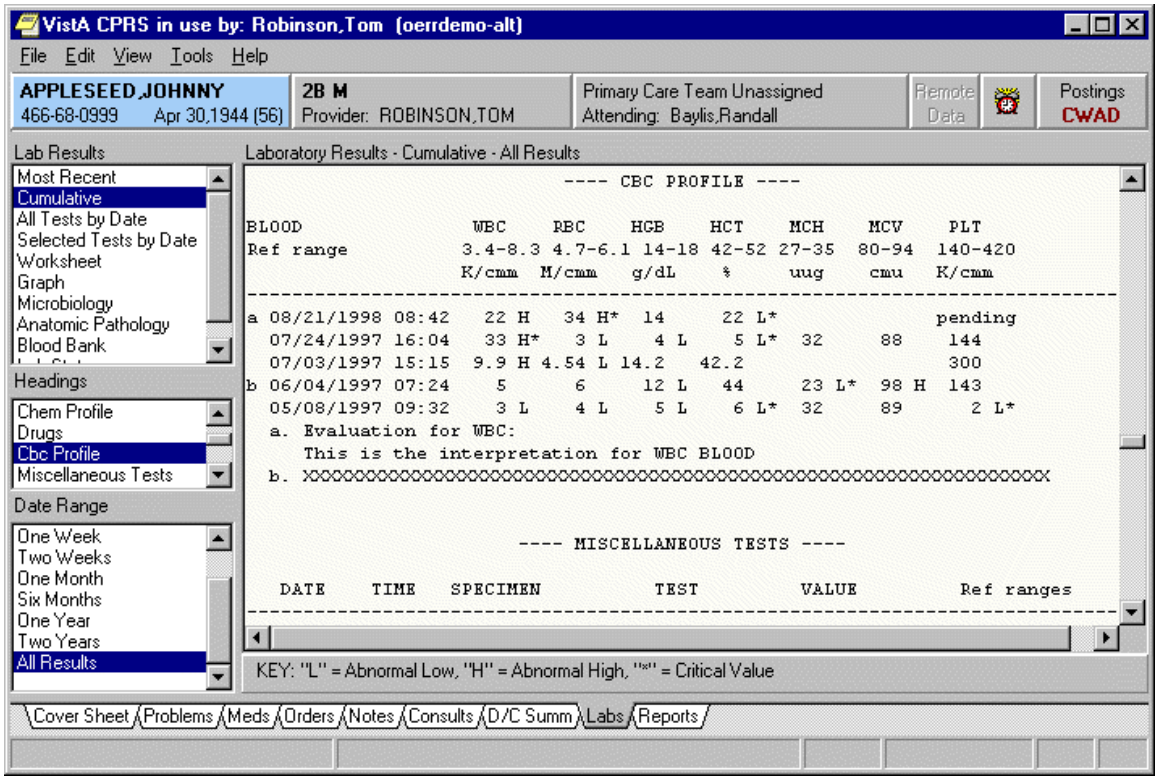
Most Recent

This report allows sequencing back through the most recent results. It displays each set of lab tests in the time they were collected/ it also displays microbiology results and any comments on the collection.



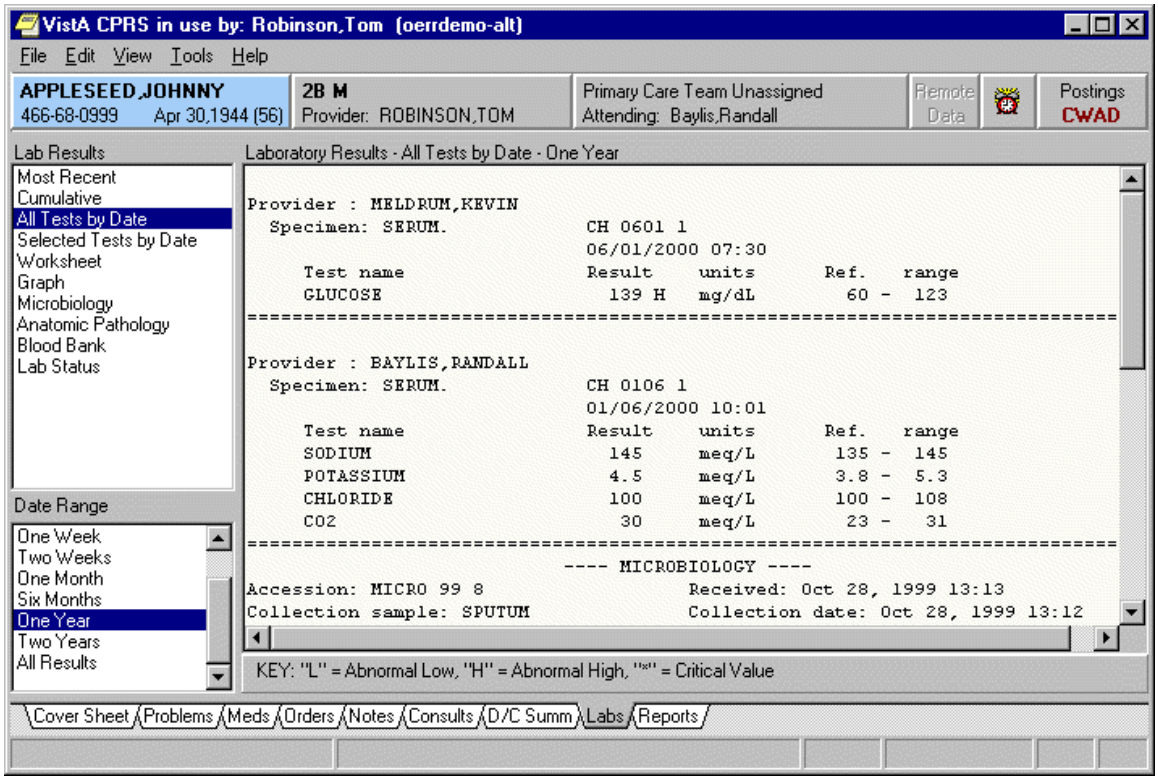
Cumulative

The cumulative report is the most comprehensive lab report. It displays all of the patient's lab results. When selecting a large data range, this report may take some time before being displayed. The results are organized into sections. You can automatically scroll to that section by selecting it in the Headings list box.



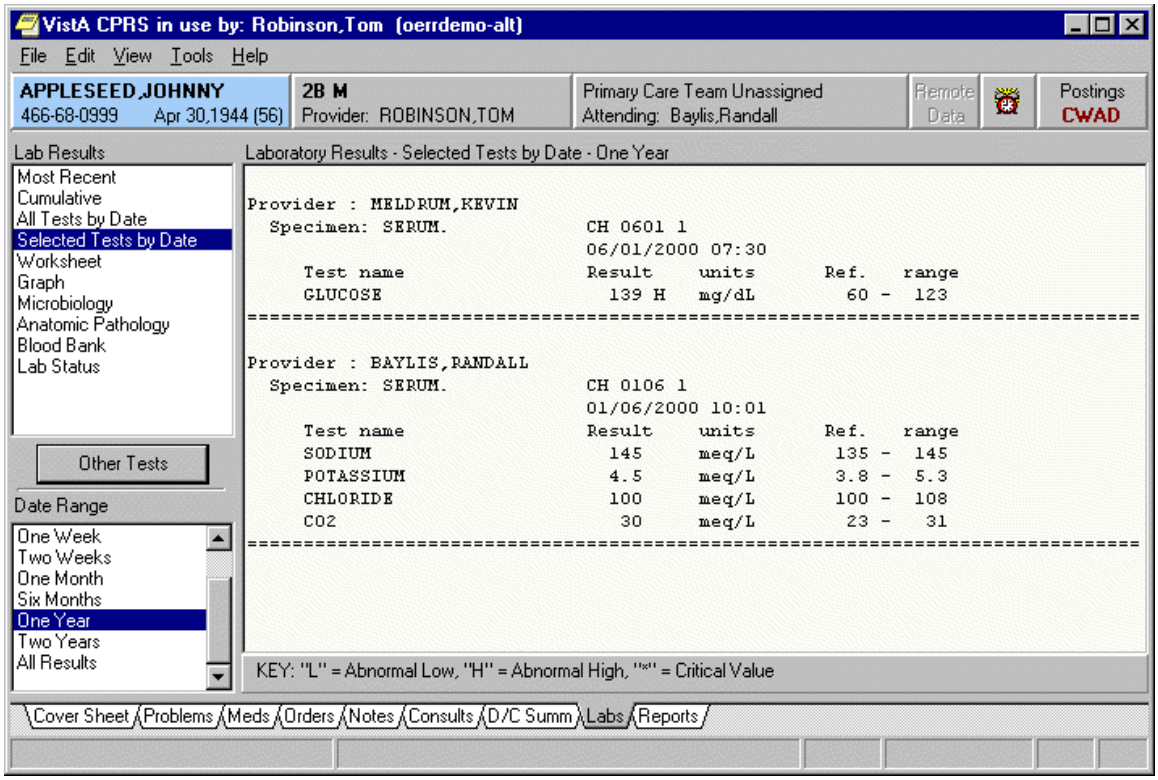
All Tests by Date

This report displays all lab results (except anatomic pathology and blood bank). The data is displayed in the order of the time of collection.



Selected Tests by Date

This report is useful when you only wish to review only specific tests. Microbiology results can also be selected. You will be prompted to select any lab tests. For example, if you select CBC, Chem 7, Lithium, and Liver Profile, only the results for those tests would be displayed.



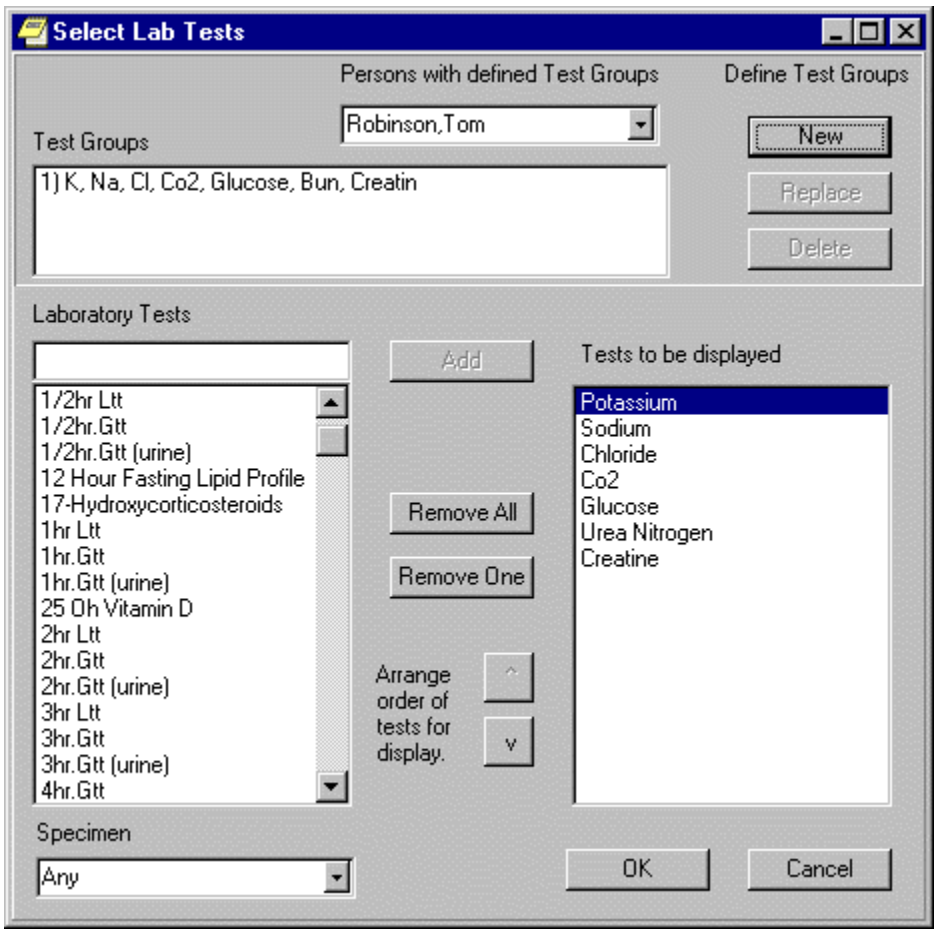
Worksheet

The Worksheet is similar to the Selected Test by Date report. It does not display microbiology results, but it has many features for viewing lab results. It is very useful for displaying particular types of patterns of results.

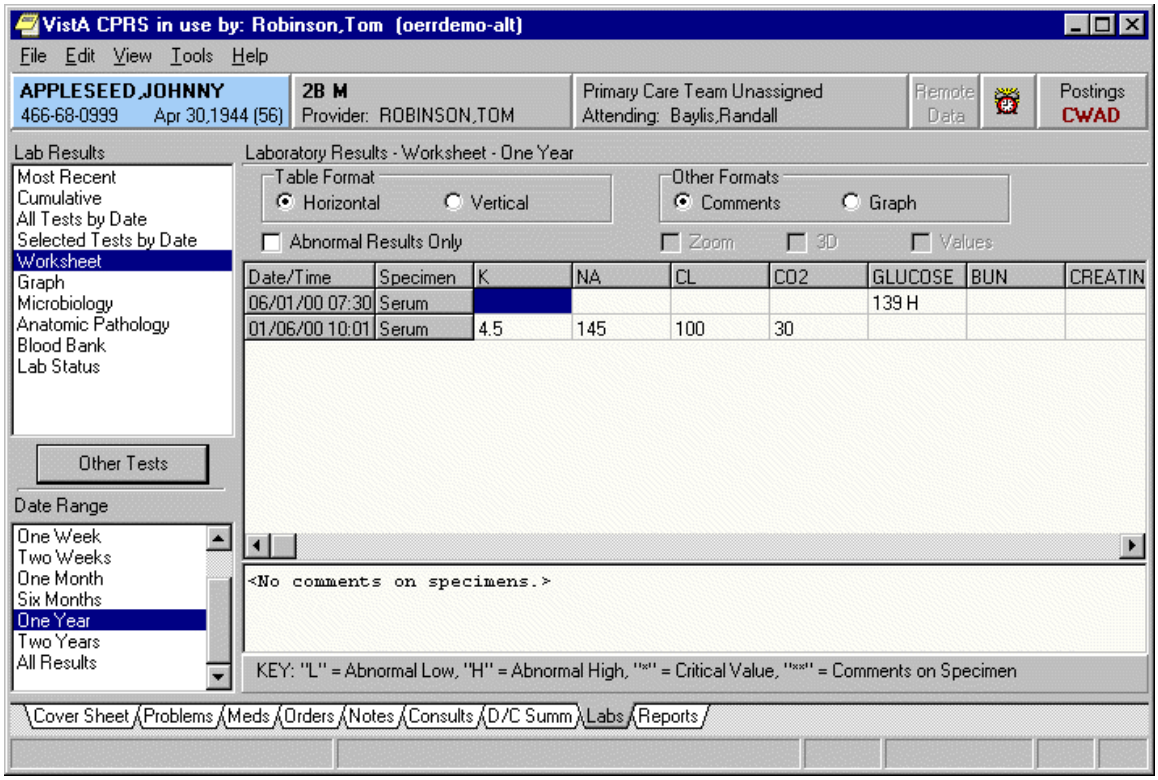
Tests can be selected individually or by test groups. Any number of tests can be displayed. When selecting a panel test, such as CBC, the panel will be expanded to show the individual tests. Tests can be restricted to only display results for a specific specimen type. For example, displaying glucose results only on CSF can be accomplished by selecting the specimen CSF and then selecting the test Glucose.

Test groups allow you to combine tests in any manner. For example, a test group could combine CWBC, BUN, Creatinine, and Platelet count. You can save those test groups for later use. You can also select test groups that other users have created. You cannot exchange or delete other's test groups, only your own. Test groups are limited to seven tests, but you may have an unlimited number of test groups. To define your own test groups, select those tests you want and click on the New button. If more than seven tests are selected, the New button will be disabled. If you want to delete a test group, deselect it and click on the Delete button. If you want to replace an existing test group with other tests, select the test group, make any changes to the tests to be displayed and click on the Replace button.

> **Note**: These test groups are the same as those you may have already created using the Lab package. The seven-test restriction is a limitation of the Lab package.



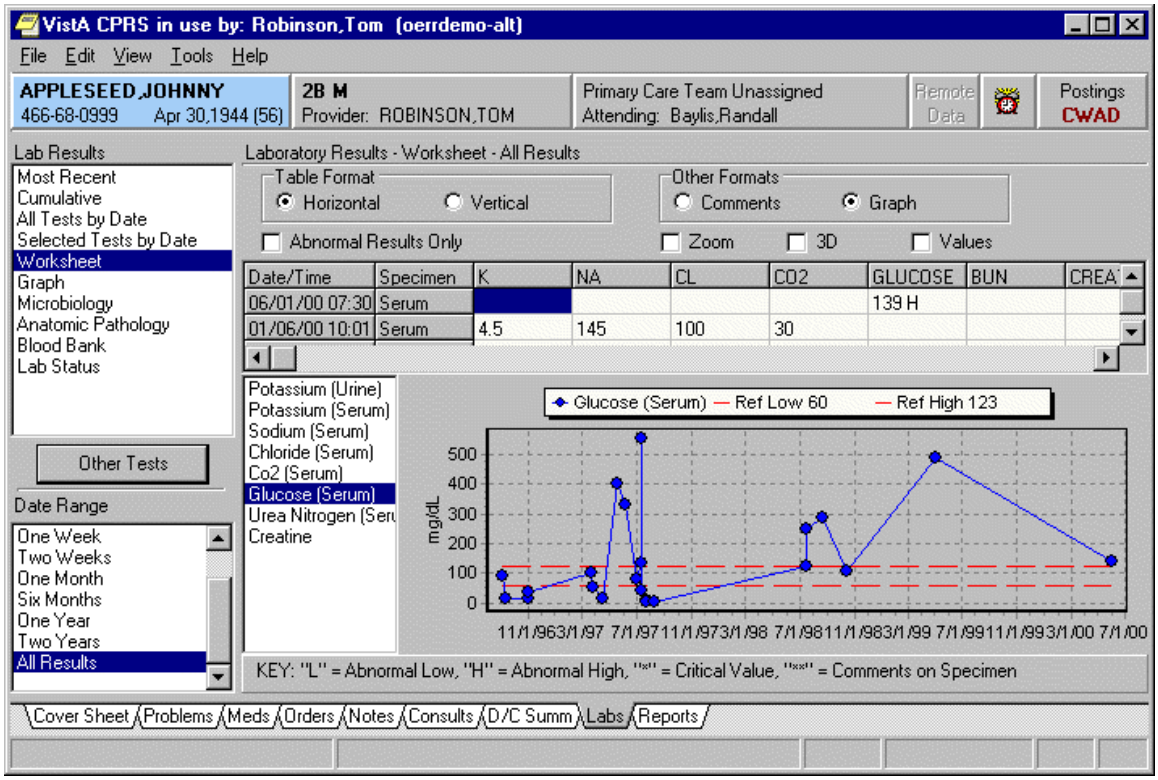
The Worksheet display is a table of results that can be displayed vertically or horizontally. Since only results are displayed in a table, comments are footnoted with a ** and shows in the panel below the table. You can filter the results to only show abnormal values. This will quickly show tests that have results beyond their reference values.



You can toggle between view comments and graph view. The graph format displays each test separately. By selecting each test, you see the trend in values for each time range. You may also use features to Zoom, apply 3D, and display values on graph. Zooming is allowed when checking the Zoom check box. You may then click on the graph and drag a rectangular area to zoom in on. To undo the zoom feature, you can uncheck the Zoom check box or drag a rectangular area in the upper left corner of the graph and then release the mouse button.

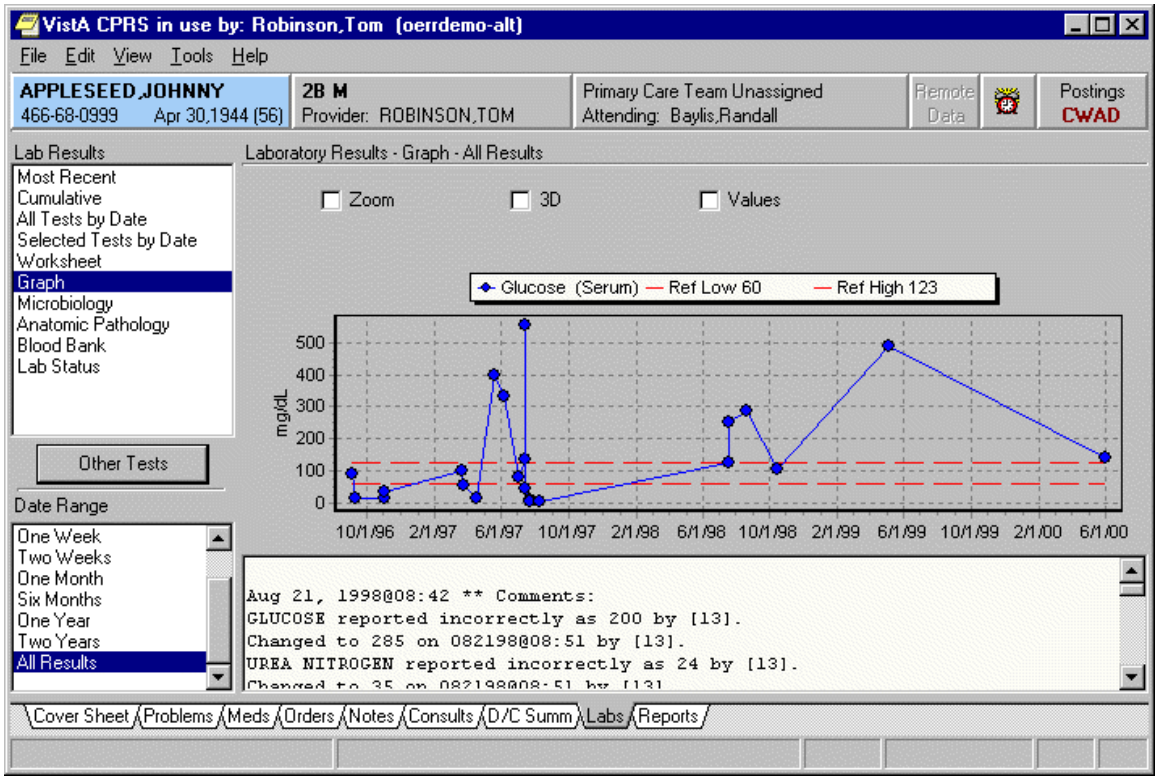
> **Note**: Zoom will retain the selected date range when you change to other tests or test groups. This is helpful when you are looking for trends within a given time period.

A right-click on the graph will bring up a pop-up menu with other actions. You can display details of the lab test by right-clicking a point on the graph and then selecting Details. This will display all test values for this collection time. Right-clicking on the graph will display all values for the selected test.



Graph

This report displays a single test in a graph. Comments are included. Zoom, 3D, and Values function the same as in the Worksheet graph. The right-click actions are also the same.

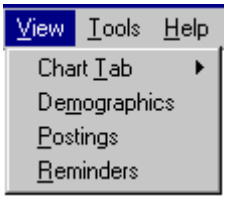


Microbiology, Anatomic Pathology, Blood Bank, Lab Status

These reports display only the results from these portions of the laboratory. The Lab Status report displays the status on current orders.

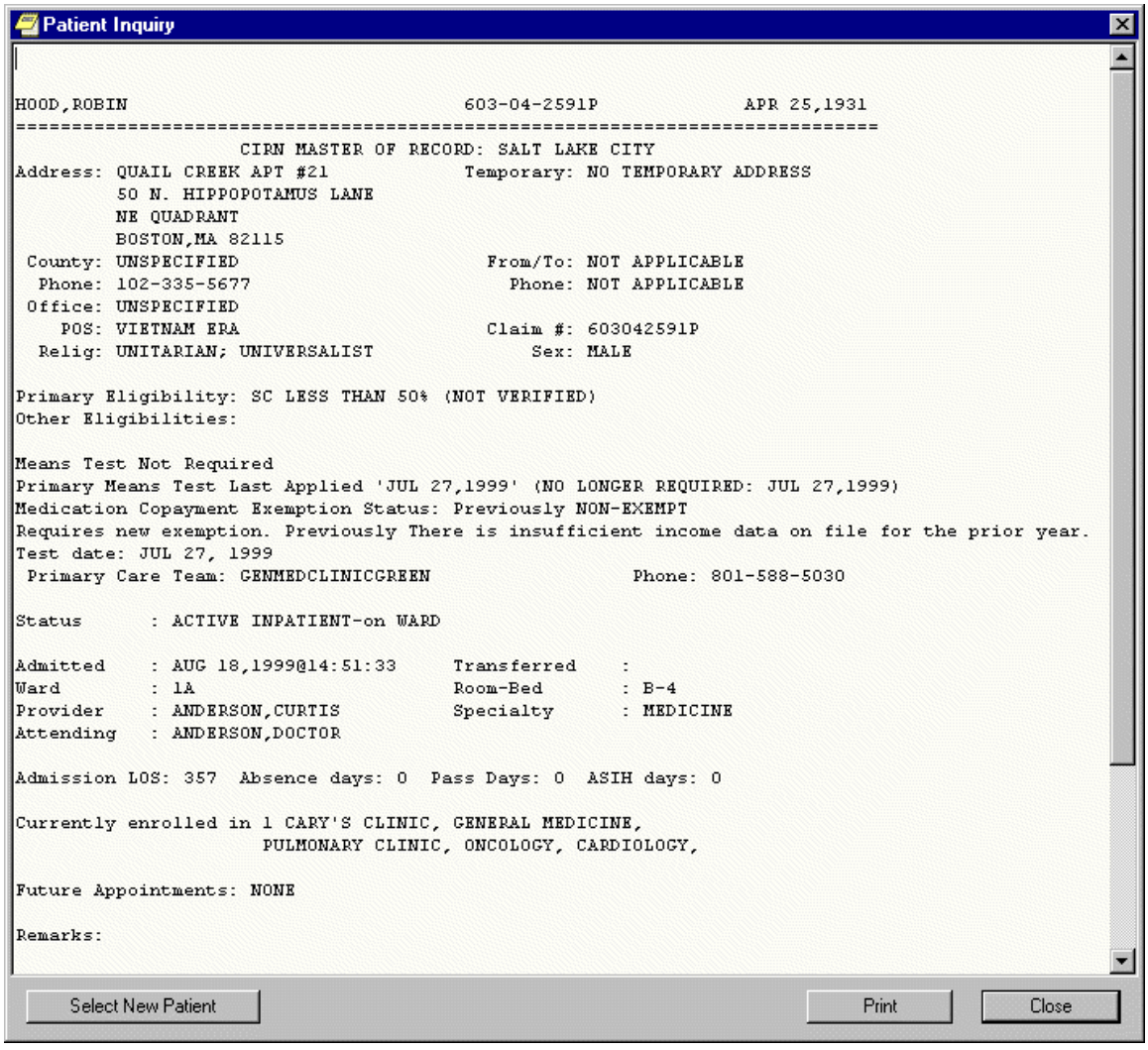
Changing Views on the Labs tab

The View menu on the Labs tab is different from most of the other tabs in that the menu options do not sort or focus the listed items. The menu items are a way to open different windows and displays with information the clinician may need to see in conjunction with the lab results.



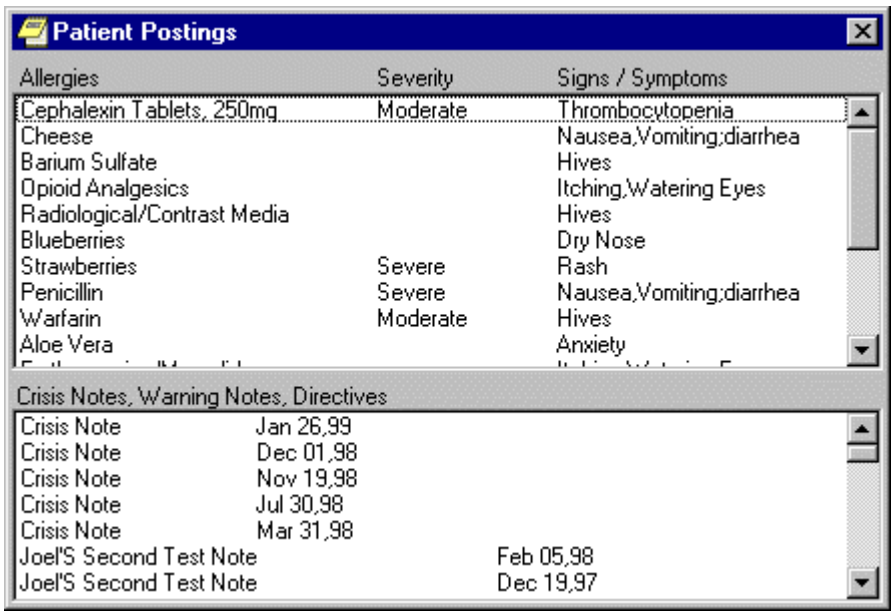
Demographics

From the Labs tab, click on View | Demographics to display the Patient Inquiry screen of the currently selected patient.



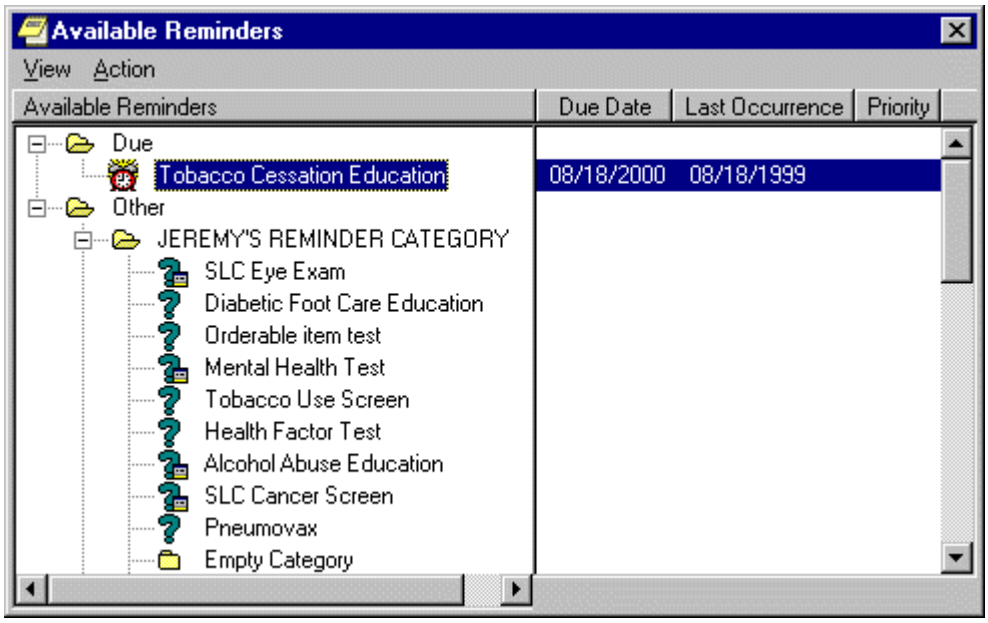
Postings

From the Labs tab, click on View | Postings to display the Patient Postings screen of the currently selected patient. The Patient Postings windows displays information about the patient's allergies, and any Crisis Notes, Warning Notes, and Directives that may apply to the patient.



Reminders

From the Labs tab, click on View | Reminders to display the Available Reminders dialog for the currently selected patient. The Available Reminders dialog allows you to review all reminders including the ones that apply to the currently selected patient.

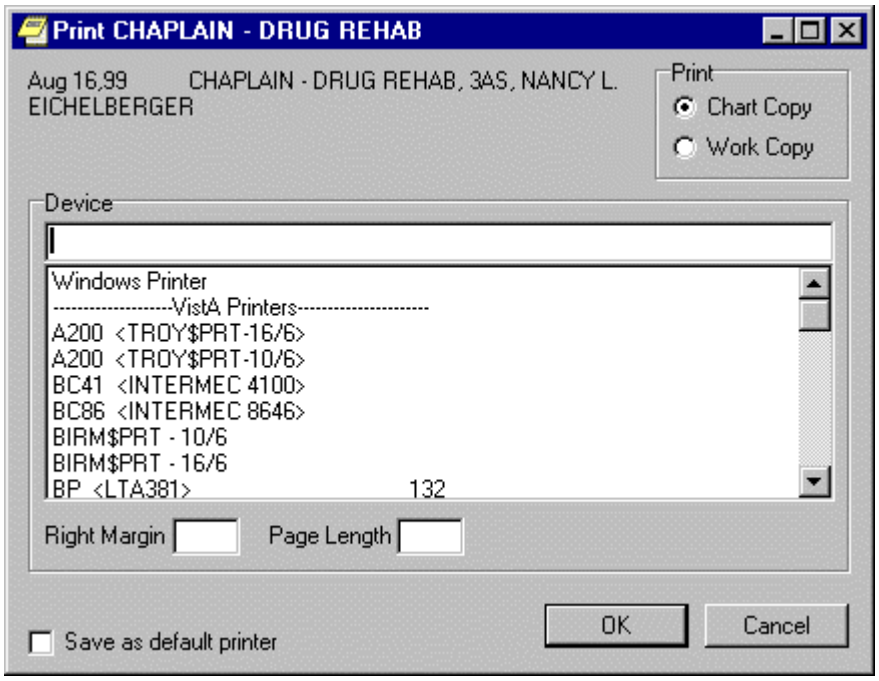


Reports

Currently, you can print reports from the Problems, Consults, Labs, Notes, Discharge Summary, and Reports tabs to any VISTA printer defined on the server or to a Windows printer.

You can also now print graphics on a Windows printer from the Labs tab and the Vitals screen. You can use **File | Print Setup...** to set up a preferred printer for the current session and save it as the default for the user.

The dialog box shown below comes up when you select **File | Print** from the Notes tab. A similar dialog, without the Chart copy / Work copy option appears for items on other tabs. Many report boxes now have Print button on them to make it easier for you to print the information you need. With most reports you can select a date range and sub-topics to customize your reports.



Normally, you do not need to enter a right margin or page length value. These values are measured in characters and normally are already defined by the device.

You will also still have the options to print your regular tasked jobs.

Viewing a Report

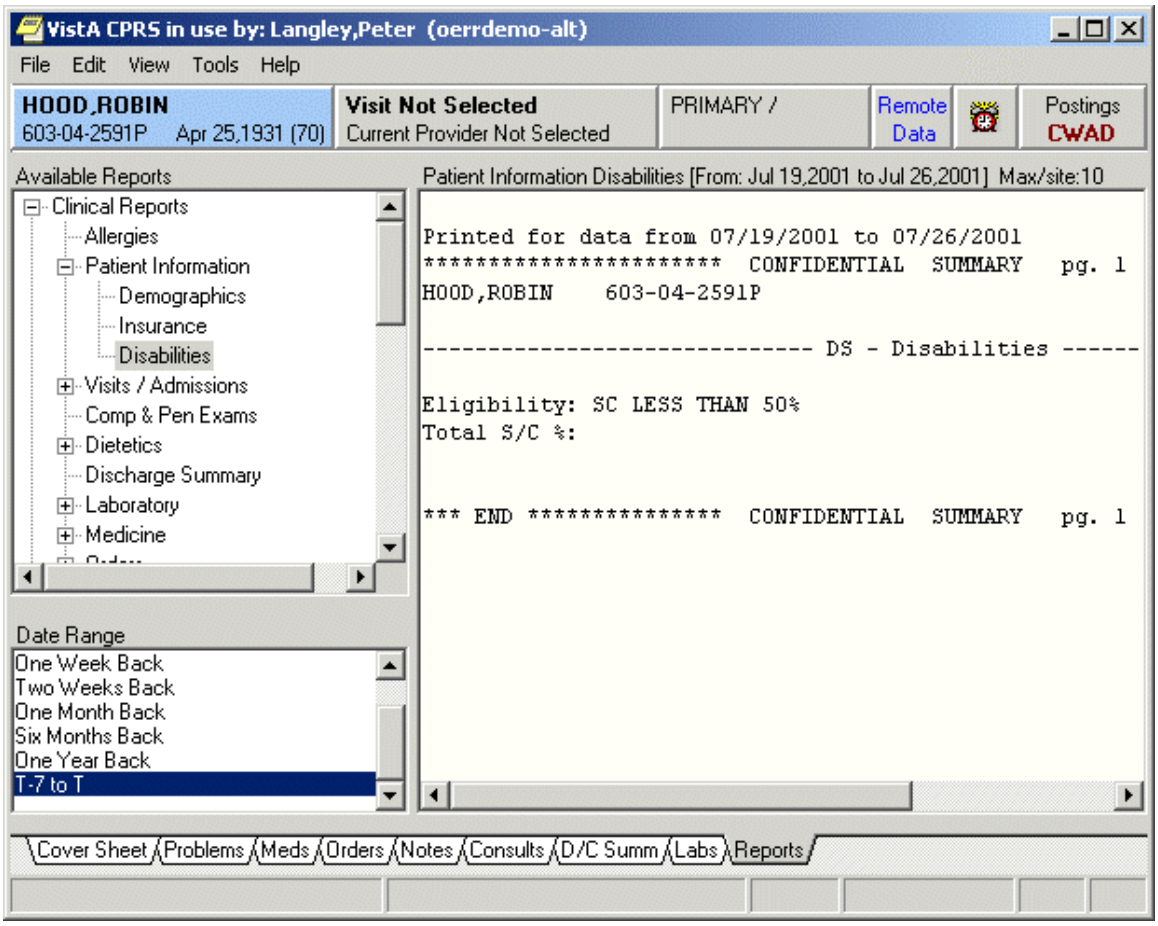
To display a report, follow these steps:

1. Click the **Reports** tab.
2. Select the report you want to view from the Available Reports box (click the "+" sign to expand a heading).

   Note: all of the reports available in CPRS version 15 are available in this version of CPRS in the new tree view format. The next section, "Available Reports on the Reports Tab" lists the location of each report.

3. If necessary, select a date range from the Date Range box located in the lower left corner of the screen.

The report should be displayed either after step 2 or step 3. You can then scroll through and read the report. If the report is in tabular form, click on a row to reveal details about that row (to select more than one row press and hold the **Control** or **Shift** key).



Available Reports on the Reports Tab

The table below lists the reports available from the Reports tab. A "+" sign indicates that the topic is a heading that can be expanded. The letters "DOD" next to a report indicate that the report can display remote data from Department of Defense medical facilities. Please note that the location of the reports may be different depending on the configuration of your site.

+ **Clinical Reports**

  Allergies

+ Patient Information

    Demographics

    Insurance

    Disabilities

+ Visits / Admissions

    Adm./Discharge

    Expanded ADT

    Discharge Diagnosis

    Discharges

    Future Clinic Visits

    Past Clinic Visits

    ICD Procedures

    ICD Surgeries

    Transfers

    Treating Specialty

    Comp & Pen Exams

+ Dietetics

    Generic

    Diet

    Nutritional Status

    Supp. Feedings

    Tube Feeding

    Dietetics Profile

    Nutritional Assessment

    Discharge Summary

+ Laboratory

- Blood Availability
- Blood Transfusion
- Blood Bank Report
- Surgical Pathology - **DOD**
- Cytology - **DOD**
- Electron Microscopy
- Lab Orders - **DOD**
- Chem & Hematology - **DOD**
- Microbiology - **DOD**

+ Medicine
  - Abnormal
  - Brief Report
  - Full Captioned
  - Full Report
  - Procedures

+ Orders
  - Orders Current
  - Daily Order Summary
  - Order Summary for a Date Range
  - Chart Copy Summary

+ Outpatient Encounters / GAF Scores
  - Education
  - Education Latest
  - Exam Latest
  - GAF Scores
  - Health Factors
  - Immunizations
  - Outpatient Diagnosis
  - Outpatient Encounter
  - Skin Tests
  - Treatment Provided

+ Pharmacy
  - Active Outpatient - **DOD**
  - All Outpatient - **DOD**

Outpatient RX Profile

Active IV

All IV

Unit Dose

Med Admin History (BCMA)

Med Admin Log (BCMA)

\+ Problem List

Active Problems

All Problems

Inactive Problems

\+ Progress Notes

Progress Notes

Advance Directive

Clinical Warnings

Crisis Notes

\+ Radiology

Report - **DOD**

Status - **DOD**

Imaging (local only)

Imaging

Surgery Reports

Vital Signs

\+ **Health Summary**

Adhoc Report

Diabetes

Ac Clinical Summary

Radiology

Pain Management

Remote Demo/Visits/Pce (1y)

Remote Demo/Vists/Pce (3m)

Remote Clinical Data (1y)

Remote Clinical Data (3m)

Remote Clinical Data (4y)

Global Assessment Functioning

Discharge Summary

Imaging (local only)

Lab Status

Blood Bank Report

\+ **Anatomic Path Reports**

Electron Microscopy

Surgical Pathology

Cytopathology

Autopsy

Anatomic Pathology

Dietetics Profile

Nutritional Assessment

Vitals Cumulative

Procedure

Daily Order Summary

Order Summary for a Date Range

Chart Copy Summary

Outpatient RX Profile

Med Admin Log (BCMA)

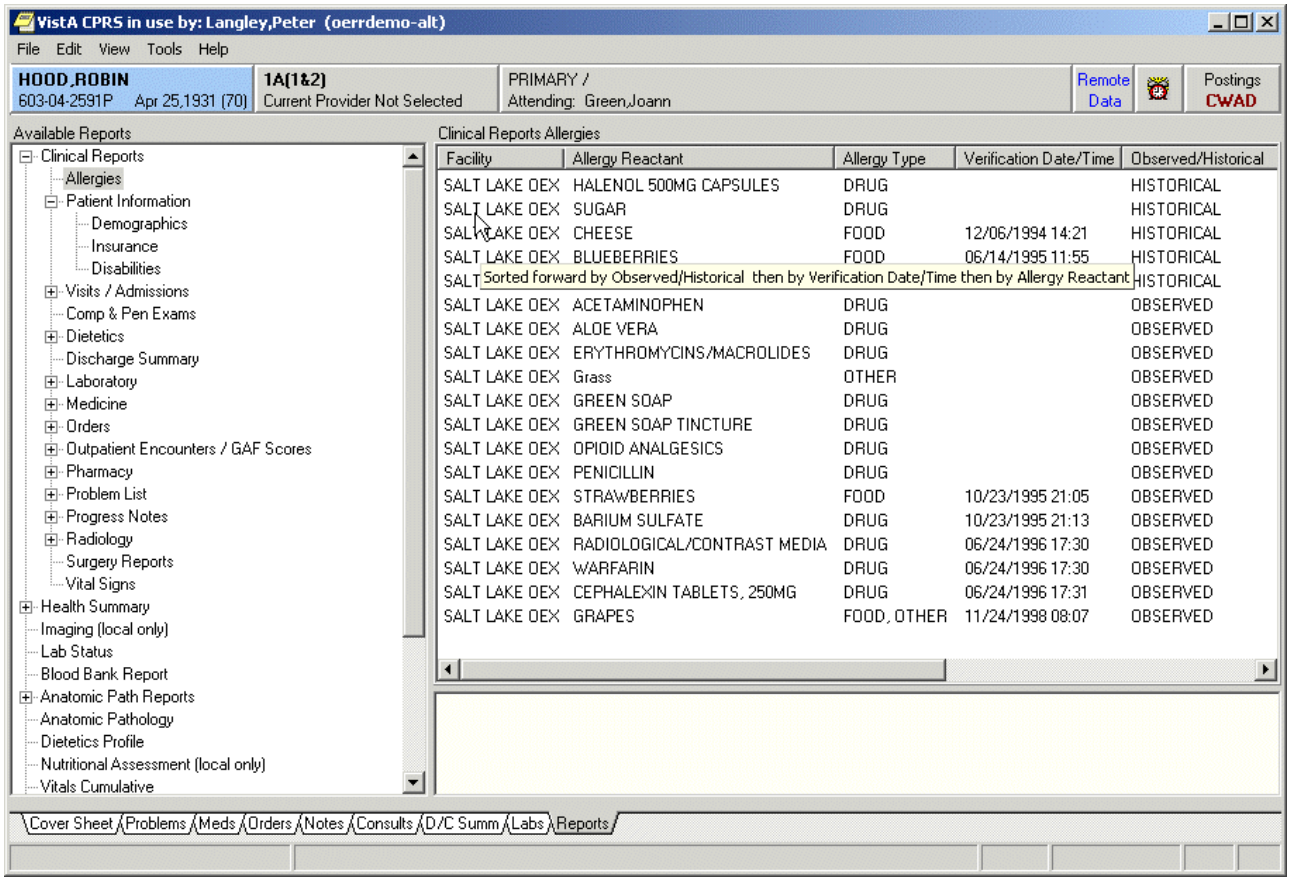
Med Admin History (BCMA)

Sorting a Report (Table View)

If a report is available in a table view, the table can be sorted alphabetically, numerically, or by date. To sort data in a report table:

1. Click the column heading you wish to sort by.
2. The table will be sorted alphabetically (A-Z), numerically (0-9), or by date (most recent-least recent).
3. If you click the column heading again, the table will be sorted in inverse order (Z-A, 9-0, or least recent-most recent).
4. To perform a secondary sort, click on another column heading.

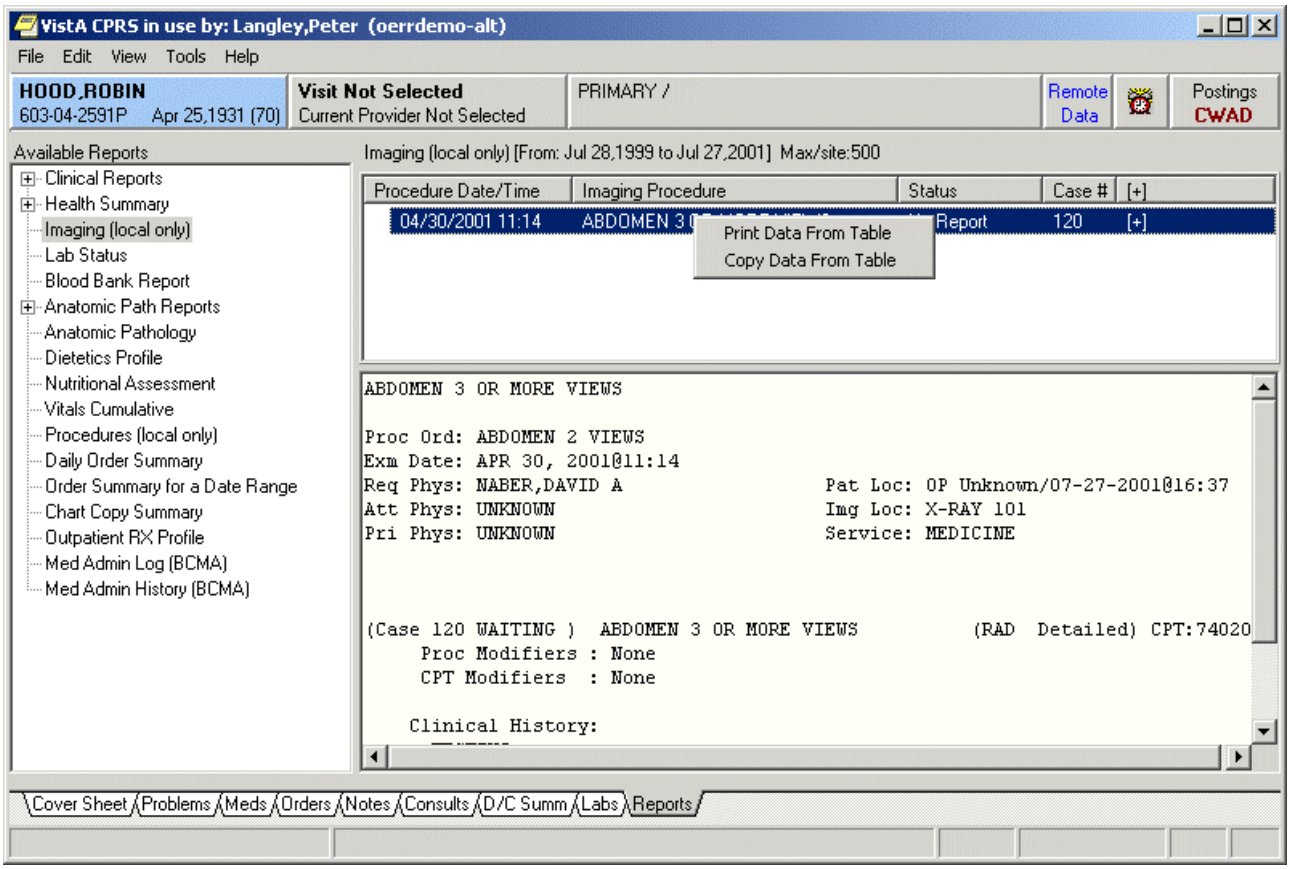
Note: If you hold the pointer over the table, a hover hint will appear with the criteria used to sort the table.



Printing a Report

To print a report, follow these steps:

1. From the Reports tab, select the report you would like to print.
2. If the report is in text format, right click on the text of the report
   or
   if the report is in table format, click on the row that contains the data you would like to print (to select more than one row, press and hold either the **Shift** or **Control** key). After you have selected the appropriate row(s), right click on the area or row you have selected.
3. Select **Print** (text format) **or Print Data From Table** (table format).

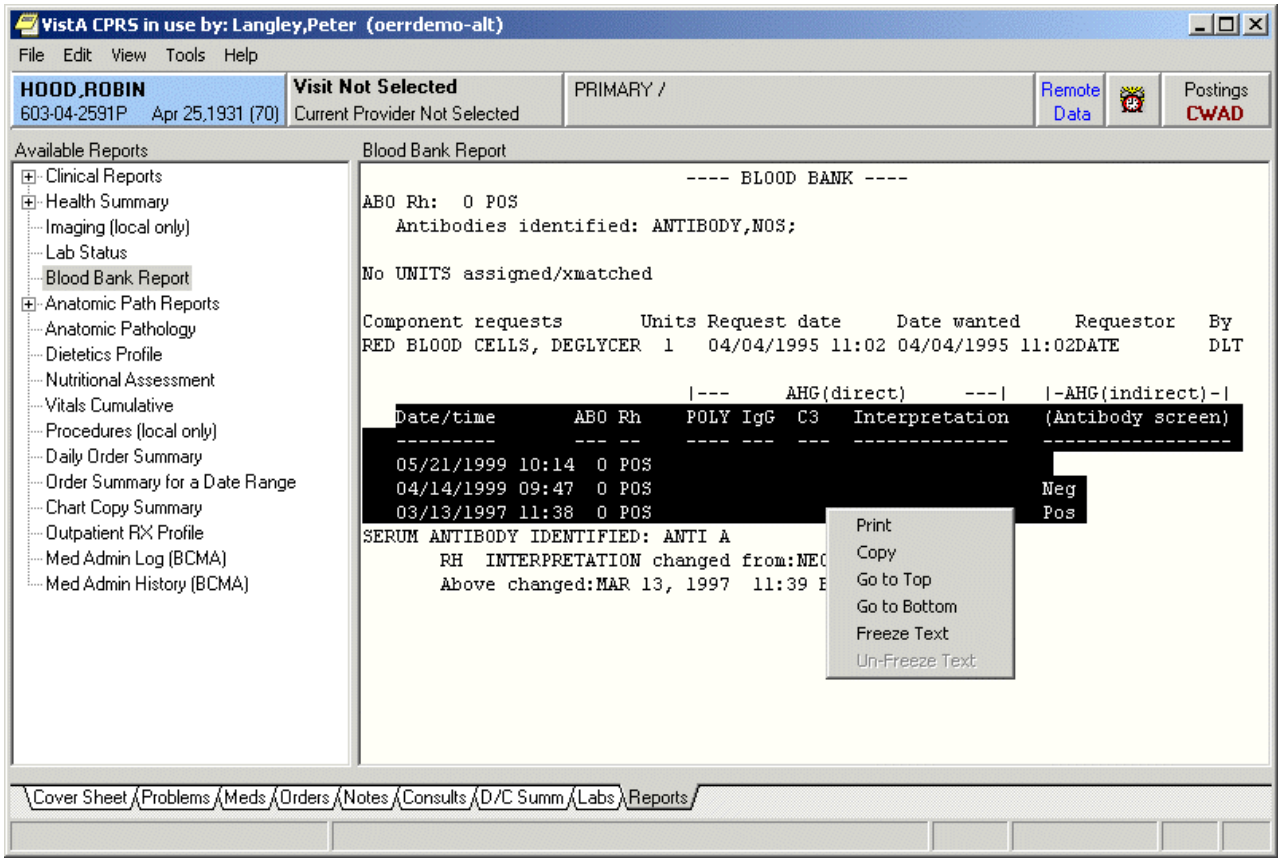


Copying Data from a Report

To copy data from a report, follow these steps:

1. From the Reports tab, select the report you would like to copy data from.
2. If the report is in text format, select the text you would like to copy and then right-click
   or
   if the report is in table format, click on the row that contains the data you would like to copy (to select more than one row, press and hold either the **Shift** or **Control** key). After you have selected the appropriate rows, right-click on the area or row you have selected.
3. Select **Copy** (text format) or **Copy Data From Table** (table format).

You can now paste the data into another area in CPRS or into another program.



Viewing a Health Summary

To display a Health Summary, follow these steps:

1. Select a patient after you enter the CPRS system.
2. Select the **Reports** tab.
3. Under the Available Reports box on the left side of the screen, click the "+" sign in order to expand the Health Summary heading.

4. Select a Health Summary by clicking on the summary that you would like to see. After you have selected a summary, the appropriate data is displayed on the right side of the screen.

5. Use the scroll bar on the right to scroll through the different sections of the Health Summary.

Glossary

CPRS	Computerized Patient Record System, the VistA package (in both GUI and character-based formats) that provides access to most components of the patient chart.
AICS	Automated Information Collection System, formerly called Integrated Billing; software developed at Albany IRMFO, supported by MCCR, producing scannable Encounter Forms.
ASU	Authorization/Subscription Utility, a VistA application (initially released with TIU) that allows VAMCs to assign privileges such as who can do what in ordering, signing, releasing orders, etc.
CAC	Clinical Applications Coordinator. The CAC is a person at a hospital or clinic assigned to coordinate the installation, maintenance and upgrading of CPRS and other VistA software programs for the end users.
Chart Contents	The various components of the Patient Record, equivalent to the major categories of a paper record; for example, Problem List, Progress Notes, Orders, Labs, Meds, Reports, etc. In CPRS, these components are listed at the bottom of the screen, to be selected individually for performing actions.
Consults	Consult/Request Tracking, a VistA product that is also part of CPRS (it can function as part of CPRS, independently as a standalone package, or as part of TIU). It's used to request and track consultations or procedures from one clinician to another clinician or service.
Cover Sheet	A screen of the CPRS patient chart that displays an overview of the patient's record.
CWAD	Crises, Warnings, Allergies/Adverse Reactions, and Directives. These are displayed on the Cover Sheet of a patient's computerized record, and can be edited, displayed in greater detail, or added to. *See Patient Postings.*
D/C Summary	Discharge Summary; see below.
Discharge Summary	A component of TIU that can function as part of CPRS, Discharge Summaries are recapitulations of a patient's course of care while in the hospital.
GAF	Global Assessment of Functioning is a rating of overall psychological functioning on a scale of 0 – 100. The GAF tab is available in the CPRS GUI in VA Mental Health facilities.
GUI	Graphical User Interface—a Windows-like screen with pull-down menus, icons, pointer device, etc.
Health Summary	A **V***IST***A** product that can be viewed through CPRS, Health Summaries are components of patient information extracted from other VistA applications.
Imaging	A VistA product that is also a component of CPRS; it includes Radiology, X-rays, Nuclear Medicine, etc.

Notifications	Alerts regarding specific patients that appear on the CPRS patient chart. They can be responded to through “VA View Alerts.”
OE/RR	Order Entry/Results Reporting, a VistA product that evolved into the more comprehensive CPRS.
Order Checking	A component of CPRS that reviews orders as they are placed to see if they meet certain defined criteria that might cause the clinician placing the order to change or cancel the order (e.g., duplicate orders, drug-drug/diet/lab test interactions, etc.).
Order Sets	Order Sets are collections of related orders or Quick Orders, (such as Admission Orders or Pre-Op Orders).
PCE	Patient Care Encounter is a VistA program that is part of the Ambulatory Data Capture Project (ADCP) and also provides Clinical Reminders, which appear on Health summaries.
PCMM	Patient Care Management Module, a VistA product that manages patient/provider lists.
Patient Postings	A component of CPRS that includes messages about patients; an expanded version of CWAD (see above).
Progress Notes	A component of TIU that can function as part of CPRS.
Quick Orders	Quick Orders allow you to enter many kinds of orders without going through as many steps. They are types of orders that physicians have determined to be their most commonly ordered items and that have standard collection times, routes, and other conditions.
Reports	A component of CPRS that includes Health Summary, Action Profile, and other summarized reports of patient care.
TIU	Text Integration Utilities; a package for document handling, that includes Consults, Discharge Summary, and Progress Notes, and will later add other document types such as surgical pathology reports. TIU components can be accessed for individual patients through the CPRS, or for multiple patients through the TIU interface.
VISN	Veterans Information System Network is the collective name of the regional organizations that manage computerization within a region.
VistA	Veterans Information Systems Technology Architecture, the new name for DHCP.

Index